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ABSTRACT

Intended primarily for teachers, this book of 17 readings is an attempt to provide a brief, descriptive overview of some of the complexities of the drug abuse problem. The readings are as follows: "Student Drug Use" by Helen H. Nowlis; "Recognition of the Drug User for Enforcement Agents, Teachers and Others" by William D. Alsever; "Glossary of the Youth Subculture and Drug Scene for the Establishment and Other Uptight Adults" by William D. Alsever; "Drug Abuse Problems of Identification" by the U. S. Department of Justice; "Drugs and New Religious Cults" by C. Douglas Gunn; "The Drug Challenge" by Michael V. Reagen; "Drug Survey in Syracuse Schools" by Mayor's Temporary Commission on Narcotics Abuse and Addiction in Syracuse; "The Drug Problem in Central New York" by Greg Glassner; "The Paradox of Our Schools" by Samuel Goldman; "Presentation and Implementation of a Drug Abuse Prevention Program" by Sol Gordon; "Drug Addiction" by Edwin M. Schur; "What Is Drug Abuse? Is There a Definitive Answer?" by Daniel X. Freedman; "Drug Abuse and Law Enforcement" by Charles Delaney; "Narcotic Antagonists: New Methods to Treat Heroin Addiction" by Allen M. Hammond; "Drug Abuse--Just What the Doctor Ordered" by J. Maurice Rogers; "Mind-Altering Drugs and the Future" by Wayne O. Evans; and "Some Considerations for the Treatment of Non-Narcotic Drug Abusers" by Carl D. Chambers and Leon Brill. (DB)

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IDEAS

READINGS FOR

THE INSTITUTE FOR DRUG EDUCATION AT SYRACUSE

Michael V. Reagen, Editor

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CONTINUING EDUCATION CENTER FOR THE PUBLIC SERVICE
110 Roney Lane, Syracuse, New York 13210 (1971)

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Many individuals played important "behind the scenes" roles in the development of this volume. Several public officials who indirectly facilitated its production deserve recognition: The Honorable John Mulroy, County Executive for Onondaga County; Dr. Donald Bordreau, Commissioner of Mental Health for Onondaga County; Dr. Harold Rankin, Superintendent of Schools for Jamesville-Dewitt School System; New York State Senator Tarky Lombardi; and, Rayburn Hess of the New York State Narcotics Addiction Control Commission.

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Special mention must be made of Wanda Hoffman, a Ph.D. candidate at the Maxwell School for Citizenship and Public Affairs. Mrs. Hoffman was the true shepherd of the volume's development. She prepared the manuscript for printing and provided the editor with invaluable assistance.

Without the cooperation of generous authors and publishers, inclusion of much of the material in this volume would not have been possible.

Syracuse University
September 1971

Michael V. Reagen

INTRODUCTION

The substances we refer to as "drugs" have been used -- in one form or another -- by people since the start of recorded history. But the rampant misuse of drugs appears to be primarily a twentieth century, American phenomenon.

The fact that millions of our citizens -- representing all walks of life and all age groups -- are abusing a wide variety of substances for, apparently, many different reasons should perplex all thoughtful Americans.

Our current "drug problem" has obvious cultural and pathological implications which threaten to recast the basic fabric of our society. We have several theories about why we have a drug problem and many notions about preventing and treating it. But we do not have any real answers.

In fact, as a society, we are expending more energy publicizing drug abuse than we are in trying to understand it. We are spending more funds to cope with it than we are in researching basic questions about it. Only recently have we begun to seriously and systematically attempt to study drug abuse.

American history is rich with examples of the development of solutions to societal problems before the problems themselves were clearly defined. We are an impulsive people who have a tendency to act swiftly more than wisely.

This book of readings was not designed to be a definitive work; rather, it merely represents an attempt to provide its reader with a brief, descriptive overview of some of the complexities of the drug abuse problem.

Although the intended audience for this volume are teachers in the twenty-one school districts of Onondaga County, New York, we who have prepared this book hope it will gain wider circulation.

Our purpose in producing this book is to stimulate all its readers to learn more about the drug abuse dilemma. Unless every responsible American commits himself to continuing his education, we can never hope to humanely and practically deal with the complex problems of our dynamic society.

Michael V. Reagen

Syracuse University
September, 1971

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LIST OF NAMES OF PEOPLE AND AGENCIES IN ONONDAGA COUNTY INVOLVED IN VARIOUS DRUG PROGRAMS AND SERVICES

Abbot, Lee	Probation Officer, Onondaga County Probation
Alsever, William	M.D., Syracuse Univ. Health Service; Board of Directors of Argosy House; Hospital of the Good Shepard
Bell, William	Administrative Director, Argosy House
Boudreau, Donald	M.D., Commissioner of Mental Health, Onondaga County
Catalano, Ralph	SU Graduate Student; research in dangerous drugs
Cerio, Joseph	A.C.S.W., Social Work Supervisor, St. Mary's Hospital
Clark, William	NYS Narcotics Control Bureau
Clover, Raymond	Organizes narcotic guidance
Cooney, Mrs. Carol	Supervisor, Onondaga County Probation
Delaney, Charles	Lieutenant, Onondaga County Sheriff's Department in charge of narcotics unit
Detor, Robert	Administrative Director, D.E.N.
Dixon, Mark	Educational Director, D.E.N.
Domenic, Miss Theresa	Psychiatric Services, Nursing Supervisor, St. Joseph's Hospital
Doran, Mrs. Bernadine	R.N., Head Nurse, Medical Rehabilitation, St. Mary's Hospital
Fenlon , Miss Julia	R.N., Nursing Supervisor, St. Mary's Hospital
Ferro, Mrs. Barbara	Assist. Dir. Psychiatric Serv., Coordinator, Methadone Maintenance, St. Joseph's Hosp.
Fritz, Charles	Director of NYS Aftercare Treatment Center
Foulk, Miss Erline	Voc. Rehab. Counselor, Methadone Maintenance, St. Joseph's Hospital

Gallagher, William	Head Nurse, Methadone Maintenance, St. Joseph;s Hospital
Gianopoulos, Mrs. Chris	Assistant to Dr. D. Boudreau, Onon. Col. Mental Health
Gulgusky, Miss Judy	Social Worker, Medical Rehab., St. Mary's Hospital
Hale, Emile	NYS Narcotic Addiction Control Commission
Hallenbeck, Jere	Executive Director, Argosy House
Hermann, Ed	Assist. Director, Onondaga County Probation
Higley, Walter	Chairman of the Board, Argosy House
Holt, Edwin P.	NYS Narcotic Addiction Control Commission
Hourrigan, Dennis	After care Officer, NYS Narcotic Addiction Control Commission
Hulse, Harry	Program Director, Argosy House
Hurley, Brother Cornelius	works with Argosy House, Regional Director
Jackson, Henry	Director of D.E.N.
Joffe, Sidney	NYS Narcotic Control Bureau
Leachtenauer, Mrs. Ruby	Director, Information and Referral Service for Volunteer Center
Levine, Michael	M.D., Upstate Medical Center & Neighborhood Health Center; Medical Director at 1012.
Levy, Mrs. Molly	Director, Information & Referral, Onondaga County Health Department
Levy, Stephen	CNY Regional Planning Board, Crime Control Planner
Linehan, Martin	Probation Officer, Onondaga County Probation
Mace, Douglas L.	M.D., Director, Drug Treatment Center, Vet. Administration Hospital
McKaig, James	Investigator, NYS Police Narcotics Unit, Troop D Hg., Oneida

Mondanaro, Josette	Medical Committee on Human Rights, President, 4th year Medical student at Upstate, staff member at 1012.
O'Dea, Mrs. Gloria	Public Health Nursing Coordinator Onondaga County Health Department
Osborne, Rev. Richard	Catholic Social Service, Catholic Charities
Osgood, Charles	M.D. Works with methadone detoxification at Van Duyn Hospital
Pelz, Inspector Andrew	Health of Organized Crime Section of Syracuse Police Department
Reagen, Michael	Program Administrator, Institute for Drug Education at Syracuse (IDEAS), Continuing Education for the Public Service
Richards, Stephanie	Resident Director at Argosy House
Sweet, Don	Welfare Dept., worker, works with and helped found 1012, has done extensive other work in Syracuse with drugs, especially in hard drugs and with Blacks.
Taylor, Herbert	Head Nurse, Psychiatric Unit, Upstate Medical Center
Tierney, Mrs. Sheila	Director of Nurses, St. Mary's Hospital
Wilhelmina, Sister M.	Administrator, St. Mary's Hospital

A. PREVENTION

New York State Narcotic Addiction Control Commission
677 South Salina Street
Syracuse, New York 13202

Telephone: 474-5951, Ext. 461

Director: Emil Hale
Edwin Holt

Jurisdiction: 9 counties including Madison, Onondaga, Cayuga, Chennango, Cortland, Jefferson, Oswego, Schuyler and Tompkins

Function: Primary objective is to disseminate information to adults and their children via PTA meetings, workshops in the schools, church groups, etc. They also distribute written material provided from their central office concerning the facts on dangerous drugs.

Onondaga County's Narcotics Guidance Council
Dewitt Community Church
Erie Blvd. E. and Grenfell Road
Dewitt, California

Telephone: 446-3262

Chairman: Rev. Alexander C. Carmichael

Members: Dr. William D. Alsever, Mr. C. Daniel Shulman, Mr. William E. Robbins, and Miss Joan Martha Howard.

B. TREATMENT

Argosy House Inc.

Telephone: 474-2456 (Offices and Counseling Center, Midtown Plaza, Syracuse)
475-4217 (Residences, 830 Westcott Street, P.P.Box 155, Onondaga Branch, Syracuse)
422-3443 (Store Front Counseling Center, 117 Water St., Syracuse).

Executive Director: Jere Hallenbeck
Resident Director: Stephanie Richards
Administrative Director: William Bell

Jurisdiction: Primarily Onondaga County

Function: Rehabilitation of addicts and drug dependent individuals through use of abstinence program in a residential theraputic community. Emphasis of program on young drug abusers. There is also a Day Center for counseling, education of teachers and professionals. It also serves as a court liaison for drug users who are apprehended and need treatment.

1012 Program
503 South Crouse Avenue
Syracuse, New York 13210

Telephones: Emergency lines: 476-DRUG and Syracuse University Ext. 3784. Business line: 476-6692

Director: 1012 does not have a Director per se. However, 1012 is a sub-committee of the Syracuse chapter of the Medical Committee for Human Rights, of which Josette Mondanaro is president.

Resident Director: 1012 does not have a single Resident Director. However, there is a full-time resident staff of 7 at the present time, each of whom handle various aspects of the program and who collectively may make or suggest decisions on general policy.

Jurisdiction: Primarily East Side and University hill area of Syracuse.

Function: 1012 is primarily a crisis center in all respects, although in terms of drug problems, 1012 handles primarily soft drug cases. Physicians, lawyers, and psychiatrists are on call at all times, and 1012 is open 24 hours a day. 1012 also handles runaways, those in need of pregnancy and draft counseling, and a great many referrals for legal problems and medical problems, as well as referral for those in need of long-term counseling. Hard drug cases are referred to D.E.N. and Argosy House. 1012 also makes available a lecture series dealing with drugs.

1012 Crisis Center
805 Madison St.
Syracuse, N. Y.

Telephone: 476-6692

Function: 24-hour, 7 day a week walk-in center for anyone with any sort of problem.

New York State Aftercare Center
State Office Building
333 East Washington Street
Syracuse, New York 13202

Telephone: 474-5951, Ext. 460

Director: Mr. Chester Fritz
Robert Wozna

Jurisdiction: 19 counties including Onondaga, Madison Cortland, Cayuga, Chemung, Chenango, Jefferson, Broome, Lewis, Oneida, Ontario, Oswego, Schuyler

Functions: Provides counseling for addicts who have been released from drug rehabilitation centers and also conducts periodic urine tests to determine if they are refraining from further use of opiates.

Van Duyn County Hospital
West Seneca Turnpike
Syracuse, New York

Telephone: 469-3201

Staff: Dr. Charles Osgood
Dr. Arthur Bubey

Jurisdiction: Generally Onondaga County

Function: Accepts addicts for methadone withdrawal treatment upon referral from D.E.N. Two beds are available for detoxification at the hospital.

Direction and Education in Narcotics (D.E.N.)
Kirk Field House
Onondaga Creek Boulevard
Syracuse, New York 13207

Telephone: 475-5898

Executive Director: Henry Jackson
Administrative Director: Robert Detor
Educational Director: Mark Dixon

Jurisdiction: City of Syracuse (primarily Inner-City)

Function: Provides screening process for all individuals who desire admittance to Van Duyn Hospital for detoxification. In addition, D.E.N. provides referral and educational services for the rehabilitation of drug users. Ex-users and ex-addicts are included as members of the staff to deal with the drug problem.

C. ENFORCEMENT

New York State Narcotic Control Bureau
677 South Saline Street
Syracuse, New York 13202

Telephone: 474-5951, Ext. 567

Director: Sidney Joffe
Bill Clark

Jurisdiction: Counties of Broome, Cayuga Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, and Tompkins.

Function: Main responsibility is to prevent a diversion of dangerous drugs from legal sources such as hospitals, nursing homes, physicians, veterinarians, dentists, and pharmacies. Provide technical assistance to all law enforcement agencies and police training academy's concerning dangerous drugs. Agency is responsible for the licensing of legitimate narcotic drug distributors such as hospitals and pharmaceutical houses.

New York State Police
Troop D, Headquarters
Oneida, New York

Telephone: 1-363-4400

Investigator: James McKaig

Function: Troop D has a Narcotic Unit which includes Onondaga County in its jurisdiction. Members of the unit also give talks on drugs.

Syracuse Police Department
Public Safety Building
Syracuse, New York 13202

Telephone: 473-5510

Chief of Organized Crime Unit: Andrew Feltz

Jurisdiction: City of Syracuse

Function: The organized Crime Section of the Syracuse Police Department, in addition to enforcement of Narcotics Control Laws, also give numerous talks to interested groups.

Onondaga County Sheriff's Department
Public Safety Building
Syracuse, New York 13202

Telephone: 477-7683

Director of Narcotics Unit: Lt. Charles Delaney

Jurisdiction: County of Onondaga

Function: The Onondaga County Sheriff's Department has a Narcotics Squad which, in addition to enforcement, also is involved in education through public speaking.

Bureau of Narcotics and Dangerous Drugs
Department of Justice

Local Enforcement officer:
James Sullivan
United States Attorney
Northern District of New York
U. S. Federal Building
Syracuse, New York

Telephone: 473-6660

Jurisdiction: Northern District of New York

Function: Investigation, enforcement, and prosecution - Federal narcotics laws.

D. GENERAL

Suicide Prevention Service

Telephone: 474-1333 day and all night

Function: Provides emergency consultation anytime day or night for anyone who is experiencing an emotional crisis. Person does not have to be thinking about suicide to use this service.

Community Information and Referral Service
Volunteer Center in Syrac use

Telephone: 471-9131 or 471-8126

Function: Provides guidance to the services a person might need. No appointment is necessary.

HIRS (Health Information and Referral Service)
Onondaga County Health Department Building

Telephone: 477-7431

Functions: Provides guidance to resources which will both help treat physical health problems and provide support to the family in which the problem occurs.

Cephus House
315 Allen St.
Syracuse, N. Y.

Telephone: 479-6907

Functions: Provides 24-hour counseling services for teenagers and referral to appropriate agencies.

Soule Clinic
775 Irving Ave.
Syracuse, N. Y.

Telephone: 475-9321

Functions: Provides counseling to individuals and families where the drug alcohol is being abused.

STUDENT DRUG USE

Helen H. Nowlis*

Student drug use is a highly emotionally charged topic for virtually everyone. For an increasing number of people "student" arouses bewilderment, frustration, even anger, and "drug" adds a measure of panic, fear, revulsion, and indignation. Together they hardly provide a climate which is conducive to clear thinking and to constructive action.

What I would like to do this afternoon is to share with you some of the experiences I have had during the past three years as a psychologist, an educator, and an erstwhile psychopharmacologist who has been concerned with all aspects of this complex problem. I have managed to become involved with students who use a wide variety of drugs in a variety of ways and for a variety of reasons, with students who do not use drugs, with scientists from biochemists to sociologists, with professionals from medicine and education to various aspects of the mass media, with legislators who make laws and with enforcement personnel who are charged with enforcing those laws, as well as with diverse segments of the general public.

I hope that many of you will not be disappointed that we will be discussing only incidentally the prevalence of student drug use, the kinds of drugs they use, and the outcomes of drug use. There are others who can do this better than I. In this connection I would strongly recommend that anyone who is concerned with any aspect of student drug use become thoroughly familiar with both the methodology and the conclusion of Blum and his associates in his two important recently published volumes, Society and Drugs and Students and Drugs. My own role has been that of psychologist analyzing the problem, interpreting the research of others, assessing the current state of our knowledge and relating it to what is considered by many to be one of society's major problems. At least bills related to drug use and abuse have been introduced in the current session of Congress.

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*This is an address presented by Dr. Nowlis at the Annual meeting of the American Psychological Association, Washington, D. C., Sept. 2, 1969. On Sept. 3, 1971, Dr. Nowlis was sworn in as the first director of a drug abuse program in the U. S. Office of Education. This article will also appear in Psychology and the Problems of Society. Washington, D.C., American Psychological Association (In Press).

Although I shall be discussing one particular problem, I would like to suggest that it is a prototype for many other problems which involve individuals and groups of individuals, society's response to some of the things they do, and psychology's role in contributing to the understanding of these problems and, hopefully, to their solution. I would also suggest that without being aware of it or without intending to do so, many of us actually contribute to these problems simply by the way we report our research. Once was the time when we could talk only to each other, and we developed a special elliptical discourse which, in most instances, communicated effectively and efficiently. We no longer talk only to each other, and our discourse -- jargon for others -- with all of its implicit assumptions is getting us into trouble. Our so-called conclusions are spread abroad by and to people who do not understand sampling and correlation and experimental controls and significance of difference and the prevalence of error, who do not read or understand our operational definitions, our null hypotheses, or the limited validity and reliability or our measures. They surround every word we use with their own apperceptive mass. The current "drug problem" is an excellent example of what can happen. One scientist reports chromosome breakage in a "significant" number of white blood cells as a result of adding LSD in a test tube, and the word spreads across the nation and reverberates in the halls of Congress that LSD is threatening future generations. I am not at all sure how we can cope with this problem, but it might be helpful if each of us reread his Summary and Conclusions as if he were John Doe and perhaps added a "may" or an "in some cases," hopefully specified. We may even have to include a new final paragraph, "Cautions." It may not enhance one's ego or one's pleasure over significance at the P=.01 level of confidence, but it certainly would help in educating non-scientists in the proper use of scientific information.

"Student drug use" has been widely interpreted as the "spread of narcotic addiction from the ghetto to our middle class and suburban youth," a threat to the future of our society. In the wake of this increasingly widely held feeling, it is almost impossible to study student drug use or to discuss it objectively. In the face of society's decision to consider much of this drug use criminal, it is difficult even to study it. In estimating incidence of use, of adverse effects, of any drug-related phenomenon we have many numerators but virtually no reliable denominators. The challenges involved in persuading students that their admission to having committed a felony will be confidential and, indeed, being able to guarantee that confidentiality are sometimes great.

Within the limits of the time available I would like to discuss the nature and extent of student drug use, its meaning and significance, society's response to it, and some of the problems resulting from efforts to control it. But before we do this we must define some terms lest we add to, rather than reduce, the confusion and controversy which exists.

The first term we must define is "drug." In our society there are two widely accepted definitions of "drug," and both of these contain many implicit assumptions. One defines drug as a chemical useful in the art and practice of medicine; the other defines drug as a "narcotic" with narcotic defined as a socially disapproved substance or an otherwise approved substance used for socially disapproved reasons. Many problems result from definitions based on the purposes for which a drug is used. For example, there is the fact that one and the same substance may be a medicine under one circumstance and a "narcotic" under another or not even a drug under still another. Secondly, there is a great temptation to study one type of drug or drug use out of the context of all drugs. Third, there is a tendency to assume that the use of all drugs which fall under one definition has the same significance and the same effects. This has led to complete confusion in surveys of student drug use. One investigator will ask if the individual has used any drugs without the advice or supervision of a physician, another will ask if the individual has used specific socially disapproved drugs (with the list varying from survey to survey), and at least one has surveyed a wide span of drugs, including social drugs such as alcohol and tobacco, home remedies, painkillers, prescription drugs, over-the-counter drugs, as well as exotic and illicit drugs. Only the latter is in any real sense a survey of student drug use. You will note that I have carefully avoided the word abuse. We will come to that later.

What is needed is a definition of drug which is objective and descriptive and does not have within it a variety of implicit value judgments which are the source of much of the confusion and controversy which abounds in discussions of drugs and drug use. The basic pharmacological definition of drug as any substance which by its chemical nature affects the structure or function of the living organism is about as descriptive and objective as one can be. This definition includes a wide range of substances. It includes both medicines and socially disapproved substances, and it also includes a wide range of substances which we do not call drugs ordinarily, such as beverage alcohol and caffeine, nicotine, agricultural, industrial, and household chemicals, pollutants, even food. For many purposes this is too broad a definition, but it forms a base from which we can select groups of drugs, and it forces us to make explicit the basis on which we make a given classification. Hopefully it reminds us that a drug is a drug, and the principles by which it interacts with the living organism are the same whether we call it a medicine, a "narcotic," or by some other name.

The other term which we must define is "use." Again, there are certain advantages in starting from a descriptive and objective base. Use is often defined in terms of frequency as ever having tried, occasional, regular, or excessive. But even these terms leave plenty of room for value judgments. It is necessary to specify each in terms of actual frequency of use over specified time. Whatever one's definition of excessive, it is then at least explicit.

This is perhaps the point at which we should consider abuse and to recognize that, as currently used, both socially and legally, it has little correspondence to use as I have defined it. In other contexts and even for our national drug, alcohol, abuse is defined as a pattern of use which interferes with the psychological, social, academic or vocational functioning of a given individual. As far as many other drugs are involved, if we call them drugs, abuse is legally defined as any use of a non-medically approved drug or of a medically approved drug for a non-medically approved purpose. Our efforts to justify and support this as abuse in terms of "effects" of drugs so used are one of the main factors in the current controversy over drugs. When research indicating that monosodium glutamate injected peritoneally into pregnant mice produces offspring with neural damage, ataxia, obesity, and sterility, eminent experts testify that this is irrelevant because people do not inject MSG and, as commonly used, MSG produces the temporary and relatively minor symptoms of Chinese restaurant syndrome in only a few individuals. When the same type of evidence is presented for LSD, it is used as at least partial grounds for labelling it society's most dangerous drug, placing it in a category with heroin, and singling it out for the severest criminal penalties. I am not making a case for LSD. I am merely pointing out that we are inviting controversy and charges of hypocrisy.

With all of these qualifications and with the recognition that we have absolutely no research from which we can confidently generalize to all students, what can we say about student drug use? Most students use drugs. In Blum's 1967 survey of a random sample of approximately 200 students from each of five differing west coast colleges, from 68% to 81% had used tobacco one or more times, from 89% to 97% had used alcohol, from 11% to 32% had used amphetamines, from 18% to 31% had used sedatives, from 11% to 28% had used tranquilizers, from 10% to 33% had used marijuana, from 2% to 9% had used any of a variety of hallucinogens, and from 1% to 2% had used narcotics. Lest you forget, let me remind you that these percentages represent reports of having been used one or more times. A follow-up survey in 1968 on marijuana use in the school which had shown 21% marijuana use in the initial survey showed 57% marijuana use. Reports of regular use had increased from 6% to perhaps as high as 17%. Opium use (not heroin) was estimated to have increased from 1% to 10%. Again, a word of caution. We know on the basis of a variety of surveys of institutions around the country that use of illicit drugs varies from institution to institution and from area to area. We also know that the West coast tends to be a relatively high use area. Even here, it is a small minority of students who are involved in regular use, with regular use defined as more than once a week but less than daily.

There are two surveys in the planning stage which should provide us with more adequate data on which to base generalizations. One will involve 200 colleges of varying sizes and locations, hopefully with a follow-up after two years. The other will involve a sample of high schools together with their feeder junior high schools in a four-year longitudinal study.

Estimates currently made by Dr. Stanley Yolles, Director of the National Institute of Mental Health, on the basis of results of a majority of studies which have been done throughout the country, are that from 20% to 40% of high school and college students have tried marihuana at least once. Of these about 65% are experimenting (one to ten times and then discontinuing use), 25% are social users, smoking on occasion when it is available, and 10% of those who have tried at least once use regularly, with regular defined as devoting a significant portion of their time to obtaining and using the drug. This would mean that somewhere between two and four per cent of students are regular users. This would seem to bear little relationship to statements by prominent people headlined in the news media that one out of ten students is "hooked" on marihuana.

NIMH also estimates that the use of LSD, even in relatively high use areas is low, with probably not more than five per cent ever having tried, and an even smaller percentage countrywide.

There can be little doubt that use of illicit drugs is increasing and that use is spreading both up and down the age scale. In recent years it has begun to appear at the junior high and elementary school levels. Large numbers of middle-class adults are believed to be using marihuana. We do not have and probably will not have hard data on this group (or any group) as long as possession of marihuana is a felony. In all cases it is the spread of marihuana use which is predominant. The fact that there is increasing use of a mood-changing drug should not surprise us. Mood-changing drugs are the largest single type of drugs used, even in prescriptions. The thing which is significant is that marihuana is a drug which carries the heaviest criminal penalties and a degree of social disapproval equivalent to that of heroin to most people.

The reasons for non-medical drug use are predominantly the same reasons for which man has used drugs throughout the ages, to relieve pain, to allay anxiety, to produce euphoria, and to modify experience, perception and thought. It is tempting to speculate that modern man's increased use of mood and mind-altering substances is at least in part an indication that modern man has more pain, more anxiety, less euphoria, and less satisfying experiences, but this is the kind of speculation that has gotten us into trouble. Many of the reasons that young people use drugs are in large measure the reasons that adults use drugs: for fun, to facilitate social interaction, to feel better, to relieve boredom, to escape from problems, even to protest a little. The main difference is that most adults get their stimulants and sedatives and tranquilizers from physicians and their social drug, alcohol, is legal. Their tension, anxiety, fatigue, and depression are judged to be legitimate consequences of their full participation in pursuit of socially approved social and economic goals or values. That the outcomes of their drug use are not always good is attested to by the fact that an increasing number of hospital admissions are directly attributable to drug related illness and that we have from six to nine million alcoholics, depending on how one defines alcoholic.

Please note my use of outcomes of drug use rather than drug effects. The concept of drug effect is an example of a term which may be used to communicate effectively among scientists who understand how drugs act and that they do not have within them the power to produce a specifiable and reliable effect. The average layman with his "magic-potion-notion" of drug does not understand that we are really involved in a numbers game. For example, the effective dose (ED50) of any drug is that dosage level or amount of the drug by which, not at which, fifty per cent of a given population show whatever effect is desired. The official toxic dose is TD50 and depends on how one defines toxic. Even the lethal dose (LD50) is that dosage level by which fifty percent of a group of animals die under specified conditions. The lethal dose may vary with the temperature under which the animals are kept or whether they are housed singly or in large groups. The reason for this numbers game is that the "effect" of many drugs is largely a function of non-drug factors.

"The effect" of any drug is a myth. All drugs are chemicals which are absorbed into the blood stream and interact with the complex, delicately balanced biochemical system that is the living organism. It is a system which varies from individual to individual and from time to time in the same individual. It varies with age. It varies with sex. It varies in sickness and health. One needs only to read the counterindications and the list of idiosyncratic and side effects and diseases, and of medical progress in the advertisement of drugs in medical and scientific journals to be aware of the complexity of factors influencing the effects of a drug. Effects also vary with psychological characteristics of the individual, with his expectations, and with the setting in which the drug is taken or administered. Outcomes of or reactions to use of a drug at least put the organism, physiologically and psychologically defined, into the picture and leave room for discrimination among patterns of use.

Whether outcome or reactions are good or bad is a value judgment. The widely hailed outcome of treating mentally disturbed patients with the major tranquilizers, i.e., "emptying our mental hospitals," is considered by at least one prominent psychiatrist to be the equivalent of putting the patient in a chemical straightjacket and depriving him of his right to attempt to solve his problems. The methadone treatment for heroin addiction is regarded by many, including some addicts, as a bright hope and by others as no treatment at all and as outright immoral because it substitutes dependency on one drug for dependency on another. It is just a matter of values, to be dependent or to be free of supporting one's habit on the black market.

Somewhat guardedly, Blum concludes from his data, "It is clear . . . that a variety of unpleasant outcomes can occur, but one gets the impression that very few suffer anything damaging over the long run. Thus, one can conclude, as we do, that anything but acute toxic ill effects are unlikely and that illicit-exotic drugs when used as students are now doing, for the most part, do not seem to pose serious hazards to school performance or to health." He hastens to point out that his sample did not include any information on students who had dropped out of school, and that those who remained and were studied were a select group. He also points out that his data give no indication of the possible outcomes of long-term, low-dosage use.

Yolles reports from NIMH that the incidence of serious adverse reaction to marihuana use appears to be low but also points out that as the total number of users increases, the number experiencing adverse reaction will increase, that the effects of the drug on judgment and perception might very well be a factor in automobile accidents, and that users with significant psychiatric problems might avoid psychiatric treatment as a result of this form of "self medication."

Both of these statements function as projective tests. Those who, because of their personal beliefs, attitudes, and values, believe that illicit drugs are by definition "bad" and that illicit drug use can bring nothing but harm to the individual and to society will dismiss the data and dismiss the questions. Those who attempt to be objective will advise caution until we have more data based on research. The irony is that more research will probably leave us with essentially the same dilemma.

I cannot conceive of a research design that could provide definitive answers. The number of and interactions among independent variables involved in the driving performance of individuals who have used marihuana is staggering. Administering marihuana of known composition in known amounts in a double blind situation in the laboratory to naive subjects of equivalent driving skill as measured on a simulator will tell us very little about the driving performance of individuals who, for a variety of reasons, have chosen to use an illegal drug of unknown strength and purity, who have expectations and varying amounts of experience as to the "effects" of that drugs, who choose to drive cars of varying type and condition under varying road conditions, and who have had varying degrees of experience in coping with whatever reactions they as individuals experience when they use "marihuana."

We do need laboratory research on all drugs. We need to know the ways in which they modify the biochemical and neurochemical organism. But beyond this we need to know how these changes are related to changes in behavior. This is the greater challenge. In the meantime, differences "significantly greater than chance" in situations where as many important independent variables have been controlled will not provide us with the answers to social problems, especially when they are used inappropriately by people grasping at anything that will support what they believe about drugs which, for a variety of historical and cultural reasons, have been labeled bad, dangerous, or evil.

The use of virtually all drugs involves adverse reactions or bad outcomes, including death and in some cases life imprisonment, at some dosage level in some people under some circumstances. This includes aspirin, smallpox vaccine, penicillin, alcohol, nicotine, barbiturates, amphetamines, as well as heroin, LSD, and marihuana. In this regard it is of interest that, to my knowledge, there are no known deaths directly attributable to either LSD or marihuana as pharmacological agents except Jolly West's elephant.

As we turn to the meaning and significance of student drug use, society's response to it, and efforts to control it, I want to make it very clear that I am speaking as one psychologist who is acutely aware of the fact that her background, training, and experience, her own beliefs, attitudes, and values, even her basic beliefs about the nature of man, are important factors in her analysis and assessment of these phenomena. One always hopes that awareness inspires caution. My only special qualifications to comment on this social problem are that, because of committments entered into almost adventitiously, I have been forced to look at student drug use from almost every possible point of view and have had the privilege of interacting with many representatives of disciplines and professions who espouse these points of view, including students of all shades of opinion and involvement.

If one wants to understand drug effect and drug use one must look, not solely at the pharmacological agent, but at the person who chooses to use drugs and at what he expects, wants, or believes will result from that use. We are learning to our dismay that to try to control drug use by limiting the supply of the particular drug used does not decrease drug use. Users merely turn to another substance which may involve even more risk. And in our society drugs are everywhere: legal drugs, illegal drugs, and substances which we do not call drugs.

In addition, we have mounted a gigantic campaign to persuade the public that there is a drug for every ill or misery -- anxiety, depression, tension, and the physical symptoms associated with these, irritability, fatigue, lack of success in business, in social life, in the family. This has rocketed the pharmaceutical industry to the number one profit making industry in the country, passing the automobile industry in 1967. All of this, of course, has to do with the promotion of legal drugs, both prescription and over-the-counter drugs, obtained through legal means. But I seem to remember learning in introductory psychology about a principle known as generalization. It should not surprise us that young people do not understand why we are so excited about their use of drugs for their miseries and ills and problems. It is also relevant to note that there has also been an almost equally vigorous campaign in behalf of their drugs via the news reporting of the drug scene. Just because most of us who are over thirty do not seek adventure, new experience, insight into one's self, independence, and have either found or given up looking for new insights, meaningful social relationships, creative expression, even a dash of rebellion against the restrictions that apparently go with living in a modern technological society, and a pinch of fun, we should not underestimate the appeal of anything which promises any or all of these, regardless of whether those promises can be fulfilled. This particular characteristic of many drugs does not seem to deter many of us from seeking what is promised. In addition, we have learned that many drugs are much more effective if we believe that they will be and that "sugar pills" have cured great ills and produced profound negative effects. One physician has been reported to have said facetiously, "Whenever a new drug comes on the market, rush to your physician while both he and you still believe in its powers."

It is almost trite to point out to an audience of psychologists that drug use serves different functions for different individuals. Despite this, "Escape to Nowhere" has become the banner for numerous efforts to dissuade all from the use of certain drugs. It is astounding to note how often mere use of illicit drugs is taken as an indication that the user needs psychiatric treatment. This would seem to be, in part, the result of our concept of drug abuse as a disease and our definition of any use of illegal drugs as abuse. We seem to assume both that drugs are to cure illness and that if one takes drugs he is ill. There is no doubt that some young people use drugs to escape from pressure, from anxiety, from impulses which threaten them, from the stresses and strains of growing up. There is also no doubt that some people who are ill use drugs. But unless one defines doing anything that is not socially approved as illness, the great majority of young people who use drugs illegally are not ill or in need of psychiatric treatment. Many use them because they think it is fun. Many try them out of curiosity. Many use marihuana much as we use alcohol to facilitate social interaction. Some use them as occasional respite from the pressures of increasing academic demands.

Fun, curiosity, social interaction, change of pace are all rather normal motivations. There are many ways to satisfy them. The important question is why increasing numbers of students are choosing to risk severe legal penalties by choosing to use illegal drugs. It could have something to do with society's response to their use of drugs or, perhaps more important, society's response to young people.

The very small minority of students who use illegal drugs regularly and who devote a considerable portion of their time to obtaining drugs, to using them, and to talking about their drug experiences are also a varied group. Many of them are bright enough and well enough put together to manage their drug use and still fulfill their academic obligations. Others are not. Some are convinced that drugs will solve any of a variety of problems, some developmental and some pathological. Some are sick. Again, we should ask the question, "Why illegal drugs?"

Society's undiscriminating response to all student drug use has been emotional and extremely punitive. It is outraged at many of the things some young people are doing and saying these days. There are those who would pass laws against them and even some who would shoot a few in the belief that that would serve as a deterrent. If one watches the faces of those who suggest the latter one gets the feeling that it might also serve to reduce their anger and frustration. But there are calmer voices to be heard and as yet the more violent reactions have been held in check in most cases. But the drug issue is different. For a great variety of historical and cultural reasons we have carefully nurtured attitudes, beliefs, and stereotypes about all drugs which are outside of medicine or used for non-medical reasons. Beginning with the Harrison Narcotic Act we have forged a system of criminal penalties, including mandatory jail sentences, denial of probation and parole, for possession and "sale" (sell is legally defined as sell, give or otherwise dispose) of "narcotics" which would suggest that these were greater than any crime other than treason or first degree murder. I would suggest the hypothesis that the drug issue may represent a rallying point for frustration, resentment, and anger generated by many things that young people are saying and doing and that the drug laws are a rough and ready weapon for retaliation. Many are quick to blame drugs for everything from dropping out, criticizing, and protesting to violence. Historically non-medical drug use has been associated primarily with minority groups and, with the persistent "magic-potion-notion" of drugs, drug use has been a convenient scapegoat and a ready target for aggression against these groups. Students are a fast growing minority.

Estimates of the number of persons in the United States who have used marihuana vary from 8 million to 20 million. NIMH considers that 8 million is a conservative estimate and that there may be 12 million. All of these people are criminals since they have committed a felony. They possessed marihuana. Psychology has something to say about the effects of labeling. Psychology and common sense certainly have something to say about punishment as a deterrent when the chances of being punished are somewhere near one in five-hundred. But it either is not being said or is not being heard.

Because of the nature of the law enforcement approach to the control of drug use and because of the persistent attitudes and beliefs which support that approach, the drug issue has also become a target and a rallying point for many young peoples' frustration, resentment, and charges of hypocrisy against a society which promotes the use of alcohol, is unwilling even to require registration of guns, and seems unwilling to regulate much behavior which results in thousands of deaths and injuries.

The other major approach to control of illegal drug use is that of education. I use the word reluctantly because most so-called drug education until very recently has consisted of preaching and of attempts to scare with information which was inaccurate or patently false. Much of it still is. It seems to be designed to preserve and justify our attitudes and beliefs and our laws. It obviously has not prevented illegal drug use. Some of it may have instigated use.

Drug education is desperately needed. Students need it. Parents need it. Legislators need it. Physicians need it. The general public needs it. We are living in an increasingly chemically dominated environment. Drugs are an important part of that chemical environment. One of our most urgent social problems is to learn to live wisely in it, but we cannot do this as long as we do not understand what drugs are and how they act, what risks are involved in all drug use and how they can be minimized. We also need to expand our concept of drug to include the many substances which by their chemical nature affect the structure and function of the living organism.

To do honest and sound and effective drug education, we will need all of our skills in communication and persuasion. We will have to change long held beliefs and attitudes about drugs. We will have to separate the problem of drugs as pharmacological agents from the problem of people who make value judgments about drugs, about "drug effects," about the reasons for using drugs, and about people who use drugs. The _people_ problem will be the more difficult to solve, but the solution to the _drug_ problem should make it easier.

RECOGNITION OF THE DRUG USER FOR ENFORCEMENT AGENTS, TEACHERS AND OTHERS

William D. Alsever*

Alcohol: The Alcoholic and the Problem Drinker

Not all of these signals will be seen in an affected person. The occurrence of several should suggest the possibility of uncontrolled drinking. The diagnosis should be made by the physician on your referral to him. This is important for both the safety and well-being of the individual involved and for the image of the department concerned. Mistakes are made in both directions. A stuporous head injury case may simulate the drunk. The diabetic coma (or pre-coma stage) has been mislabelled as a juicehead. Also acute alcoholism may mask the presence of severe disease discernible only to a trained doctor, but only if he is requested to examine the patient. Leave diagnosing to the doctor -- it's his bag, not yours.

The profile of the average alcoholic reveals that he is 30-50 old, a good worker, has a good record of long company service and often is a key person. He is also a rationalizer, manipulator and a con-artist as is the junkie. In addition he surrounds himself with a wall of denial as far as his drinking habits go. The following apply to both the young student and the adult who is working.

(A) Drinking Habits -- On the job drinking, hangovers, gulps drinks rapidly and resents any reference to his drinking.

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1. Escape Drinking - To avoid tension or frustration or to release anger.

2. Signal Drinking - Seems to drink on signal being motivated to drink by certain circumstances which may or may not be ritualistic, i.e., with lunch, before dinner, before retiring at night, to celebrate, to commisurate, etc.

3. Fun Drinking - Becomes necessary to drink in order to enjoy oneself at ordinary activities as party, cards, bowling, golf, fishing, football games, watching television, etc.

(B) Physical Appearance -- Red eyes, flushed face, nervous, shaky, tremors, etc.

(C) Absenteeism -- Fridays, Mondays, day after pay day and working day prior to following holiday. Prolonged lunch hour. Leaves work early. Habitual tardiness. Unscheduled vacation time taken if possible.

(D) Productivity -- Not up to customary standards in school or on the job. Homework either late, not done or poorly completed. Work on the job is diminished quantitatively and/or qualitatively. Tends to be spasmodic without a steady output as before.

(E) Accuracy -- Mistakes and errors in schoolwork or job increase in frequency. Impaired manual dexterity. Poor judgment and unrealistic decisions.

(F) Attitudes and Habits -- Changing and labile. Volatile personality who blows off readily. Intolerant and suspicious of others. Avoids boss and colleagues.

(G) Safety Record -- Poor. More accidents and near misses in the shop. Disproportionate number auto accidents and home accidents compared with non-alcoholic.

(H) Blackouts -- Temporary amnesia for an event even though did not pass out.

(I) Finances -- Repetitive borrowing from friends. Company loans and garnishments, etc.

Drugs: User of Illicit Drugs and Misuser of Legal Drugs

Not all of these signs will be noted in any one individual. The presence of several of the general manifestations should raise the question of either drug use or abnormal drinking. The general signs listed in (A) below are quite similar to those of alcoholism and are in no way specific for drug abuse. They only suggest a problem which could be drugs or alcohol. The definitive signs tabulated in (B) below many times will pinpoint drug abuse rather than alcohol abuse. Again the diagnosis is up to the doctor -- not you! Sometimes even the physician will have his problems in establishing a correct verdict. At present there is no telltale profile of the addict or the drug dependent person -- much less of the occasional episodic user of drugs. He demonstrates the same talent for manipulation, rationalization and conning that the alcoholic does.

In general there are four major differences that may be helpful sometimes in distinguishing between the user of drugs and the user of alcohol:

1. The average drug user is under 30 years of age compared with the usual alcoholic who is over 30 years old.
2. The drug user's wall of denial may be harder to demolish than that of the juicehead since drugs are not socially acceptable as is liquor.
3. The drug taker speaks in a special jargon all his own which is characteristic of both the youth counter culture and the drug subculture (see the Glossary for details). The alcoholic converses in the customary square or straight idiom of the adult world unless he happens to

be a young person. Use of this atypical vocabulary obviously does not prove that the person is a drug user. It only indicates that he is part of the current scene.

4. The individual who has been drinking excessively will always show signs of this though they may be minimal if his tolerance and experience are great. On the other hand the drug user may or may not demonstrate stigmata of contact with drugs. Somebody may be stoned out of his head without your being able to recognize it since some users possess the rare ability to suppress manifestations of drugs especially when they realize they are under observation. Others fail to get high on grass or acid but then of course they will not be a problem to you.

To further compound your difficulties there are no pathognomic signs of tripping that are infallible and incontrovertible to the average doctor. They are certainly strongly suggestive but not proof positive in a tough case. For example, some of the things listed for acid and speed are seen in acute psychoses which are not drug induced at all; dilated pupils may be present on a nervous or psychological basis completely free of any drug orientation and an insulin reaction in a diabetic may present the picture of somebody who is freaking out. Accordingly one must be extremely cautious and circumspect before accepting unequivically the diagnosis of being under the influence of or intoxicated from a drug. Charges must be made with care! Remember that everybody who freaks out is not always an acidhead, meth monster, frost freak, etc. He may have a bad head from non-drug causes.

Recognition of the Drug User

(A) General Signs: Note the resemblance to those given for alcoholism.

1. Physical Appearance: Normal or may adopt hippy look. This may be misleading as not all hippy-type young people are into drugs by any means.

2. Absenteeism: Increased and unexplained. Tardy; leaves school or work early; prolonged lunch hour or coffee break, leaving school or work for short unaccounted for reasons, etc.

3. Friends: May discard old acquaintances for new ones. Often secretive and furtive about them; will not discuss them or bring them home.

4. Productivity and Achievement: Deterioration in academic work and lessened productivity on the job. Qualitative and/or quantitative lessening of both. Intermittent or spree type effort rather than steady output.

5. Mistakes and Errors: Increased. Homework poor or missing. Less manual dexterity. Decline of decision making and judgment skill.

6. Attitudes and Habits: Alteration in habits, personality and attitudes. Personality reversal -- from shy and quiet to gregarious and noisey; from friendly to hostile, etc. Volatile and labile. Indifference, amotivation, apathy and goal reversal.

7. Safety Record: More auto accidents. Increase in home accidents and shop accidents.

8. Language: New alien vocabulary which you do not dig. Again, the use of this new mode of expression does not imply that one is behind drugs at all! It merely means that he is a member of the current youth culture and may or may not be doing drugs. See the Glossary for explanation of many of the words.

9. Finances: Surreptitous disappearance of money from the home or articles to be pawned. May steal or borrow from classmates or fellow workers things necessary to support a drug habit.

(B) Signs of Specific Drugs: Not all present in one person. Not necessarily diagnostic, but may be suggestive. Remember that certain diseases can produce all of these signs! This listing is not complete since it has been prepared for non-medical personnel.

1. Marijuana - Pot, grass, etc.

Physical - Negligible effects. Red eyes, dry cough and possibly slight tremor and incoordination. Pupils usually normal and not dilated contrary to popular opinion. Urinary frequency. Hunger for sweets.

Mental - Happy and mildly high. Talkative at first - later may be quiet and withdrawn. Laughs and giggles easily. Contented and happy. Thoughts may be incoherent and immediate memory faulty in some. After initial high and elation may become sleepy. Placid and inactive and rarely aggressive and anti-social. A few may develop feelings of fear, anxiety, panic, paranoia or depression.

Some will not get any effect from blowing grass at all. A certain number of potheads will be able to suppress the effects of their being stoned so that the diagnosis cannot be made. This is especially true if they know they are under surveillance.

Possible physical evidence:

Marijuana - May have odor of hay and odor of burning rope when being smoked. Greener than tobacco. Usually cut with inert substances as oregano, alfalfa, hay, tobacco, catnip, etc. If it has not been manicured you will see seeds and bits of stems mixed in with the ground-up leaves. Sticks or joints are typically smaller than conventional cigarettes (a few are fatter) with both ends twisted or tucked in and may be rolled in two pieces of paper (or one) which is frequently white, tan and more recently colored or figured. Pipes are of all designs and there is nothing diagnostic about them due to the infinite variations seen. A pipe with a small piece of mesh or metal screen in the bottom is a pot or hash pipe. However, roaches (butts) may be found. Likewise a crutch is often present -- a holder for smoking the roach without burning the fingers. These also vary according to locality and preference and may be bobby pin, paper clip, split paper match and all sorts of metal devices. Incense commonly present but this is also burned by non-drug using students as well.

2. LSD - Acid, etc.

Physical - Negligible effects. Most characteristic is dilated pupils. Dark glasses (shades) commonly worn although this does not prove drug use. May show slight tremor, incoordination and somewhat rapid pulse. Nausea and vomiting. Sensitivity of eyes to bright light.

Mental - Effects often bizarre and unpredictable. Vary with dose, presence of other drugs with the acid, personality and expectations of the user, conditions under which the drug is taken, etc. Disturbances of Perception - Magnification time and space. Cerebration -- May talk about increased insight, awareness, etc. May be incoherent or out of contact with reality. Poor judgment. Illusions (false response to sensory stimulus) -- walls move, etc. Hallucinations (perception of external object when no such thing present) -- may be false in nature in that that person realizes what he is seeing is not for real. Visual commonest. May be auditory, olfactory, tactile. Religious Orientation -- May be mentioned by the patient. Includes the transcendal visionary experience reported by many and also the epiphanies or visions with religious content (Christ, Virgin Mary, heaven, etc). Depersonalization or Alteration of Body Image -- body image distorted grossly or grotesquely and loss of sense of ownership of parts of body. Derealization or Reality Loss: delusion that one is invulnerable to the hostile things in the external environment so that one can fly, walk on water or stop cars with outstretched hands, etc. Responsible for a few accidental suicides. Mood -- primarily euphoria and elation followed later in the trip by depression or "blessed repose."

Typical acidhead is quiet, not argumentative, withdrawn and not physically agressive. A few become psychotic and assaultive, some develop catetonia, others may show delusions of grandeur and omnipotence and a rare individual may become truly hyperative, physically.

Possible physical evidence:

LSD now comes in all sizes, shapes and colors so there is nothing characteristic about the material. May be liquid, pill, tablet, capsule, impregnated paper, sugar cube, gum drop, licorice, tooth picks, stamps, blotting paper, tiny piece of gelatin, etc. Must be analyzed by the laboratory.

3. Heroin - Junk, scag, smack, horse, etc.

Physical - Constricted or pinned pupils. May be malnourished. Pocks -- Oval depressed scars from skin popping. On legs and arms. Nasal membrane lining inside of the nose may be reddened, moist with secretions or may show residual white powder flecks. Septum which divides the inside of the nose may be infected or perforated. All these manifestations are from use by snorting.

Tracks -- Needle marks, scars from areas of infected hits and scars overlying thrombosed (clotted) veins. Commonest sites -- the ditch or valley (inside of elbow), forearms, legs, top of hands and feet, between toes and fingers. Less well known and less frequently used areas include side of the neck (jugular vein), floor of the mouth (lingual veins alongside attachment tongue to floor of mouth) and rarely the penis (large dorsal vein on top of the shaft of the organ.)

Mental -- Initially a euphoria from the rush or flash after the hit. This then gives way to sleepiness to the point of sleeping (on the nod or nodding), and lethargy with inaction. Will offer all sorts of reasons and rationalizations for his addiction with promises to go straight and kick the habit. Blames everybody else for his problem -- never himself.

May wear long sleeves to hide tracks. May dress unseasonably warm as addicts often tend to feel chilly. May show craving for sweets, i.e., soda pop, etc.

Possible physical evidence:

Heroin -- White or brown powder with bitter taste in various containers such as glassene envelopes, foil packets, toy balloons, capsules, folded paper decks, etc. See the Glossary.

Equipment -- The works or artillery. See the Glossary for breakdown of the various components one may find as evidence of popping or shooting.

Overdose -- The OD. Typical case is comatose (or soon will be), cold, sweaty, having trouble breathing (slow infrequent respirations) and may have tenacious froth at nose and mouth resembling shaving cream. Death is common! Get to the hospital as soon as possible -- a true medical emergency.

Withdrawal Illness - Abstinence syndrome.

Generally resembles a mild case of the flu. Not severe now due to heavy cutting of junk. Not fatal as is the case with overdoses! Runney nose, sweating, watery eyes, yawning, goose flesh, abdominal and muscular cramps, nausea, vomiting, chills, diarrhea, sneezing, twitching of feet, etc. As one advances into withdrawal the previously constricted pupils become normal but then dilate.

Methadone -- Remember that this drug can be diverted to the street and can produce true physical addiction, withdrawal syndrome and overdose with death. Same clinical manifestations as with heroin.

4. Depressants - Sedatives and tranquilizers. Goofballs, downers, etc.

Three classes -- Barbiturates (amytal, seconal, tuinal, nembutal, phenobarbital) non-barbiturate sedatives (doriden, placidyl, quaalude) and minor tranquilizers (miltown, librium, valium, valmid, noludar, etc.). All produce physical addiction, withdrawal, illness and acute intoxication (overdose).

Acute Intoxication (Overdose) -- drunk without the odor of booze being present. Pupils normal size, flickering movements of eyes, staggering, slurred speech, confusion, subnormal temperature, shock, depressed slow respirations, sleepy, eventual coma and death. Medical emergency -- will die if not treated promptly!

Withdrawal Illness (Abstinence Syndrome) -- unlike withdrawal from heroin 10-15% of these patients will die! Another medical emergency! Pupils normal size, anxiety, restlessness, insomnia, agitation, sweating, nausea, vomiting, fever, delerium, tremors and muscular twitchings which progress on if untreated to generalized convulsions, shock, collapse and death. Some pillheads will also be on heroin, alcohol or stimulants (up and downs).

5. Stimulants - Amphetamines and related drugs (not amphetamines Speed, meth, crank, uppers, etc.

Two classes -- True amphetamines as benzedrine, dexedrine, methamphetamine, desoxyn etc., and stimulants that are not actually amphetamines strickly speaking (but do the same things) such as preludin, tepanil, tenuate, ephedrine, antihistamines, etc. Some are obesity pills, cold pills, allergy pills and a few are for other legitimate medical purposes.

Physical -- Restless, agitated, continual repetitous activities, perpetual motion, sweating, malnutrition and weight loss, dilated pupils, dry mouth with licking of lips, lack of appetite, compulsive actions, aggressive, itching skin due to imaginary bugs with scratching and skin infections, tremors, fast pulse, occasionally convulsions and rarely death.

Mental -- All psyched up or speeded up. Clear or confused. Insomnia. Continuous rapid talking which does not make much sense unless you happen to be a speed freak yourself (oral diarrhea with constipation of thought). Hallucinations, delerium, paranoia and maybe psychotic. Post-spree depression may occur after crashing (suicidal tendency occasionally). The speed freak (meth monster, speeder) may be very dangerous due to his tendency to be assaultive, aggressive, paranoid and sometimes psychotic. Therefore, he must be approached with caution because of possibility of physical danger to yourself unlike the typical kid who is tripping out on acid, mescaline, hashish, etc. In areas of high concentration of speeders guns and knives are often carried to protect themselves from being burned or ripped off and they may travel in gangs known as meth marauders or crank commandos in certain localities. The underground slogan "Speed kills" or "Meth is Death" is an exaggeration as not many speed freaks die. They tend rather to end up in jail, in a hospital or are forced to kick their habit. A few are murdered or killed in accidents.

6. Cocaine - Snow, Charlie, happy powder, etc.

The original "dope fiend" of years ago. Cocaine is the "rich man's speed" and all that has been pointed out above about amphetamines is generally true of cocaine. On attempted apprehension the snow bird may be the same dangerous character that the speed freak is.

It is claimed by addicts that cocaine is the most pleasurable drug of all at the gut level with its tremendous rush, flash or jolt. It is likewise the most expensive habit of all as to remain high one must hit every 2-3 hours due to its short action unlike heroin.

7. Volatile Solvents - deleriants.

Airplane glue, turpentine, acetone, gasolene, oven cleaners, toilet bowl deoderizers, freon, spray deodorizers, aerosols, foot powder, motor tune-up fluid, cleaning fluid, kerosene, paint and lacquer thinner, tire-patch cement, lighter fluid, Carbona, nail-polish remover, etc.

The huffer or flasher does his thing straight from the can or bottle, by inhaling from a rag soaked with the fluid or by sniffing under a paper or plastic bag.

High or intoxicated for 30-45 minutes (nothing characteristic about the high) followed by sleeping it off for 1-2 hours. The only suggestive findings exclusive of catching him in the act include in some chronic users red watery eyes, watery discharge from the nose which appears red and inflammed on the inside, peculiar odor to the breath and irritation and excoriation of the skin of the upper lip.

Unlike most other drugs of abuse the xylene, benzene, toluene, etc., contained in these substances can cause demonstrable physical damage to organs such as the liver, brain, kidneys and bone marrow.
A particulary dangerous type is the inhalation of various aerosols, and sprays. These all contain the propellant and refrigerant freon . Freon can displace air from the lungs and provide heart irregularities with death. Use of a bag further enhances a fatal outcome. Such cases die suddenly during or after inhaling and are known as the S.S.D. Syndrom (Sudden sniffing death syndrom).

8. Belladonna Alkaloids - Witches brew, green dragon, horror drugs, etc.

Includes legitimate medical drugs such as atropine, homatropine, belladonna, strammonium, hyocyamus, scopalamine (twilight sleep) etc.

Besides stealing these drugs from medical sources varying amounts of them are found in certain over-the-counter items obtained without a prescription such as Contact Cold Capsules, Sominex, Asthmador, Sleepeze, Compoz, etc.

They are taken alone or may be added to LSD to enhance or prolong its effects (see Salads or Combinations in the Glossary).

Produce a high wild trip like acid but lasting longer-up to 2-4 days. While the pupils are dilated its effects are different than stimulants and hallucinogens in that there is an absence of sweating combined with a flushed face, dry mouth (absence of saliva) and fever Delerium and psychoses occur.

9. Miscellaneous Drugs

Darvon -- This non-narcotic pain reliever is used by some to turn on. It may also result in an overdose which looks exactly like the OD in the junky with the added feature of convulsions. It also is fatal if not treated early.

MDA -- The love pill. A synthetic amphetamine which is quite dangerous. Might show some features of acid and speed both with added possibility of convulsions, coma, and death.

STP -- Serenity, Tranquility and Peace. Also known as the "death trip" and "D.O.A." (dead on arrival). Synthetic amphetamine combining effects of speed and acid. Some fatalities have occured. One of the most potent drugs of all.

Sernyl -- PCP, HOG, PEACE PILL, ETC. Animal tranquilizer deemed too dangerous for human use. Causes hallucinations and psychoses. Shows some features of amphetamines, belladonna and acid such as red face, dry mouth, dilated pupils, hallucinations, tremors, vomiting, delerium, etc.

GLOSSARY OF THE YOUTH SUBCULTURE AND DRUG SCENE FOR THE ESTABLISHMENT AND OTHER UPTIGHT ADULTS

William D. Alsever*

To find a word or phrase, first look in the index or key words on the left side of the page. If it is not located there, then look through the capitalized words after the definitions as these are synonyms for the index word. Most of these synonyms are not included in the index words to avoid making the dictionary unnecessarily cumbersome.

The language is constantly changing and also varies markedly with geographical location. Much of this will be somewhat out of date the day it is printed.

Special acknowledgment is due my daughter, Alice, for her numerous suggestions regarding the vocabulary and for her assistance in typing and arranging this glossary.

ACID: see LSD.

ACID ROCK: type of rock and roll music emphasizing electronically produced sounds and songs with surrealistic imagery. Originated in San Francisco and popularized by the Jefferson Airplane, the Grateful Dead, etc.

ACIDHEAD: chronic user of LSD. CUBEHEAD.

ACID TEST: costume party at which music and lights combine to mimic or enhance LSD experience.

ACTION: activity, excitement, what's going on.

ADDICTS AND ADDICTION (HEROIN): (Also see sections on Heroin, Opium and Mainlining elsewhere in glossary).

JUNKIE: Heroin addict. JUNKY, DREAMER, SLEEP WALKER, HYPE, HOPHEAD, SMACKHEAD, SACKHEAD, A.D., NEEDLE MAN, POISON PEOPLE, STONER. BEDBUGS: fellow addicts. CROWD: fat addict. CREEP: one who scores by begging, loaning needle, etc., rather than by hustling (GREASY JUNKIE). STONE ADDICT: one with very big or heavy habit. LIFER: confirmed long-time addict (CARPET WALKER). MEDICAL HYPE: one who develops addiction inadvertantly through legitimate use of narcotics for medical reasons.

(Continued on next page).

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HOOKED: physically addicted to morphine, heroin or other opiates. CAUGHT, ON THE NEEDLE, WIRED, MONKEY ON THE BACK, VULTURE ON THE VEINS.

ARMY DISEASE: opiate addiction incurred during Civil War when injection of morphine for pain was available for the first time in treating wounded. On return home some of the casualties kept their habit, some passed their habit on to civilians and others kicked their habit.

BURNED OUT: addict who has kicked the habit, one whose veins are all scarred up (LOUSED UP) or one who no longer obtains the desired effects from his drug.

CHAMP: addict who will not reveal source of his drugs regardless of heat from the authorities.

HABIT: amount of heroin used daily and equated with its cost. See CHIPPING.

CHASING THE BAG: hustling heroin.

SYSTEM: degree of addict's tolerance for the drug.

FIX: injection of junk (HIT, SHOT, JOB). WAKEUP: initial fix of the day.

PANIC: temporary scarcity of drug when supply has been cut off. FAMINE, HARD TIMES.

NODDING: falling asleep after initial rush following fix. ON THE NOD, COASTING.

PING THE PILL: removal of tiny amount of heroin from each bag. deck, balloon or cap, etc., so that eventually enough is accumulated to provide a fix for emergency use when a panic occurs.

KICK THE HABIT: to get off heroin (break the habit). Done with or without medical assistance. BREAK THE NEEDLE, TAKE A CURE, CLEAR UP, CLEAN UP, WITHDRAW, WATER OFF, SNEEZE IT OUT, GET THE MONKEY OFF YOUR BACK, GET THE VULTURE OFF YOUR VEINS, SHAKE THE HABIT, FOLDING UP, MATURING. COLD TURKEY: kicking the habit without medical help.

STRUNG OUT: not feeling well due to lack of a fix on schedule. SICK, FRANTIC, WAY DOWN.

STRAIGHT: feeling well after a fix. WELL.

WITHDRAWAL ILLNESS: ABSTINENCE SYNDROME, COP SICKNESS.

TWISTED: in act of withdrawing. AGONIES: withdrawal symptoms. YENNING: going through withdrawal illness. YEN SLEEP; restless uneasy sleep seen during withdrawal.

WINGDING: faked withdrawal illness to con doctor into giving narcotic drugs. Also to simulate symptoms of a very painful illness such as renal colic to pressure physician to administer opiates for relief of non-existent pain

(Continued on next page).

COLD TURKEY: going through withdrawal without medical help. ON THE NATCH.

HANG TOUGH; sweat withdrawal out alone without assistance or go cold turkey.

STRAIGHTEN OUT: to provide medical treatment during withdrawal to prevent development of severe symptoms.

AROUND THE TURN: completion of withdrawal by whatever method.

DRY OUT: to detoxify or withdraw from heroin, barbiturates, minor tranquilizers, alcohol or any drug that produces physical addiction. DETOX.

REVOLVING DOOR: phenomenon seen in majority of addicts treated in institutions such as Lexington, etc. Following successful withdrawal and therapy the patient is released. On release reentry into the drug scene occurs and the patient is back on the street and scoring within several hours of discharge. This pattern is repeated endlessly in cyclic fashion every time he is readmitted. Such a patient is known as a WINDER and the process he keeps repeating is the REVOLVING DOOR.

OD (OVERDOSE): near death or death from intravenous narcotism due either to excessive dose, poisoning of his stuff or more likely allergy or anaphylaxis from a filler such as quinine. OVERJOLT, OVERAMPING, FLATTENED, JAMMED UP, FALLING OUT, TAKING THE PIPE.

SALT SHOT: do-it-yourself home treatment for an OD consisting of intravenous injection of salt and water. Ineffective and irrational therapy.

A-HEAD: regular user of amphetamines. WATERHEAD, SPEEDFREAK

ALCOHOL: street names include JUICE, SAUCE, RIPPLES, GALLO, RED, GRAPES. (Last four mean wine only).

AMPHETAMINES: BENNIES, DEXES, CARTWHEELS, FOOTBALLS, LID-PROPPERS, CO-PILOTS, SPLASH, HEARTS, THRILL-PILLS, PEP-PILLS, WHITES, BROWNIES, WAKE-UPS, SWEETIES, CROSSROADS, SPEED, FORWARDS, UPPERS, TRUCK-DRIVERS, WATER, PEACHES, CRYSTALS, BLACK BEAUTIES, CROSS-COUNTRIES, JOLLY BEANS, DOUBLE CROSS, DRIVERS, ROSES, BLUE ANGELS, PURPLE HEARTS, RED DEVILS, A.M.Y., CHALK, THRUSTERS, EYE OPENERS, LOS ANGELES TURNAROUNDS, CHRISTMAS TREE - Dexamyl, STRAWBERRY SHORT-CAKE - Oberin. B-29's. ZOOM THRUST, JELLY BEANS, DRIVER, CROSS TOPS, SPARKLE-PLENTY. (Also see SPEED).

AMYL NITRITE: PEARLS, POPPERS, SNAPPERS, AMYS, SNIFFERS, AMY JOY.

ANGEL DUST: Sernyl (PCP) on parsley or grass dusted with hash. (Probably different in other areas.)

ANTIHISTAMINES: allergy drugs being abused by some in effort to get high; i.e., Dramamine, Histadyl, etc.

ANTSY: anxious, agitated, restless.

APART: confused, bewildered, flustered. Opposite of TOGETHER.

ASHRAM: a retreat for meditation.

BABY WOOD ROSE: seeds contain lysergic acid amide and are hallucinogenic (like morning glory seeds). Also called HAWAIIAN WOOD ROSE.

BACKWARDS: tranquilizers. DOWNERS.

BAD HEAD: mentally confused from taking drugs or may be unrelated to drugs. (May or may not be psychotic). SCRAMBLED BRAIN.

BAD SCENE: situation likely to produce unpleasant experience due to drug or whatever.

BAG: small package of illegal drugs; one's particular interest or thing.

BALL: good time; a party.

BAM: mixture of stimulant and depressant. BLACK BOMBER.

BARBITURATES: (Names for specific Barbiturates).
AMYTAL: BLUES, BLUE HEAVENS, BLUE JACKETS-BIRDS-BULLETS-DEVILS-88's-BANDS.
NEMBUTAL: YELLOW JACKETS, YELLOW BIRDS, YELLOW BULLETS-DEVILS-88's, NEMBEES, NEMMY, NIMBY, ABBOTS.
PHENOBARBITAL: PHENIES, PHENOS, WHITES, PURPLE HEARTS.
SECONAL: SEGGIES, REDS, RED JACKETS-BIRDS-BULLETS-DEVILS-88's, PINKS, RED LILLIES, MEXICAN REDS.
TUINAL: combination of seconal and amytal. RAINBOWS, DOUBLE TROUBLES, REDS AND BLUES, TUIES.
Other names: GOOFBALLS, BARBS, CANDY, PEANUTS, SLEEPERS, IDIOT PILLS, BLOCK BUSTERS, COURAGE PILLS, G.B., KING-KONG PILLS. GORILLA PILLS, DOLLS, STUMBLERS.

B-BOMB: benzedrine inhaler, wyamine inhaler.

BEAUTIFUL: great, awe-inspiring, exciting. Term of approval.

BEAUTIFUL PEOPLE: enlightened and aware citizens who know where things are at and understand the youth subculture. Also the jet set.

BEHIND: involved with something, i.e., behind acid means using acid INTO ACID.

BE-IN: a collection of people meeting for a specific purpose as a love-in, study-in, etc.

BELLADONNA ALKALOIDS: atropine, schopalamine, strammonium and hyocyamine. Drugs obtained from Deadly Nightshade, Henbane, Jimsonweed, Datura, etc., all of which are potent physiologically and produce bizarre mental effects. Added to acid to intensify and prolong effects or taken alone. This practice is dangerous since thorazine administered under such circumstances to bring a patient down might prove fatal. HORROR DRUGS, WITCHES BREW, GREEN DRAGON. DEATH TRIP. (Also see COMBINATIONS).

BENACTYZINE: tranquilizer in low doses and a potent hallucinogen in high doses. SOUND, D.M.Z., SAM, JB313.

BENDER: drug orgy or alcohol spree.

BENT: under the influence of a drug, upset, angry.

BEST PIECE: wife or girl friend. MAIN SQUEEZE.

BIKE: motorcycle. BIKE PACK: Motorcycle gang.

BIT: activity, type of behavior, an interest. BAG, THING.

BLUE VELVET: paregoric and pyribenzamine taken by vein. Also elixer terpine hydrate, codeine and pyribenzamine mainlined.

BLOW THE MIND: render out of contact with reality (psychotic); drastically alter the consciousness or overcome. Commonly from drugs but not always, i.e., may be overcome by a person.

BLOWING SNOW: nasal use of cocaine.

BLOW YOUR COOL: become angry, lose control. Opposite is KEEP YOUR COOL.

BLAST: a quick, strong effect from a drug. Also a good time or party (BEER BLAST). Deep drag on a joint.

BOMBITA: vial of amphetamine. Mixture of heroin, speed, and tuinal (barbiturate).

BOO-HOO: priest in Neo-American Church.

BOOK: The P.D.R. (Physician's Desk Reference) which specifies doses and reactions of legal drugs. BIBLE, P.D.R., THE BOOK.

BOOSTER: added dose taken to prolong trip.

BOPPER: young person in tune with times and hip.

BOSS: great, good. OUT OF SIGHT, GROOVY.

BOTTOM-OUT: to hit rock bottom before rebounding and starting to improve or kick a habit (i.e., drugs, alcohol).

BREAD: money, GREEN STUFF, FOLDING STUFF, SCRATCH. See CRUMBS.

BRING DOWN: something that mutes a high as food or an unwelcome person (noun). To abort a trip with or without medication (verb).

BROAD: a woman. CHICK, BABE, BABY.

BROTHER: (SISTER): term used by black man (woman) to address a black man (woman).

BUFOTENINE: chemical isolated from skin of certain toads which raises blood pressure and produces hallucination. Also found in some plants and a few mushrooms but not in bananas as recently claimed.

BUG: pester, annoy.

BUGGY: crazy.

BULB: pellet containing an active chemical within the inert powder or filler in a capsule such as Darvon compound 65. Used to trip with.

BULL: small talk, lies, JIVE.

BUM TRIP: bad or upsetting drug experience, often characterized by fear, anxiety, panic, depression or paranoia. BUMMER, BUM BEND, DOWN TRIP, BAD TRIP.

BUTCH: lesbian who plays role of male.

BUZZ: early feelings at onset of marihuana high; pleasant high (without hallucinations) from any drug or alcohol. As verb to try to buy drugs.

CACTUS: peyote cactus. See PEYOTE.

CAMP: something regarded as old fashioned and so far out of date that suddenly it becomes stylish again due to its very oldness.

CARTOON: visual hallucination. TRAIL, PATTERN.

CASE: to look over a place, to scrutinize something.

CATNIP: scented herb used for cutting grass (stretcher or filler). Sometimes sold as pot to naive. Alleged to be slightly hallucinogenic for some susceptible individuals but if so it must produce only a low high.

CAT: any male; male who is cool or with it; a swinger.

CHECK OUT: see what is going on.

CHEMICAL PROMISCUITY: multiple drug use. MULTIHABITUATION, PAN-ADDICTION.

CHICK: girl. FLIPPED-OUT CHICK is a crazy girl.

CHICKEN: cowardly; afraid.

CHICKEN OUT: not doing something for fear of consequences.

CHILL: to ignore or brush-off; refuse to sell drugs to suspected buyer.

CHIP: use drugs only now and then. JOY POPPING, DABBLING.

CHIPPING: infrequent use of heroin or other opiate. EXPERIMENTING, DABBLING, SMALL HABIT, WEEKEND HABIT, SUNDAY HABIT, MICKEY-MOUSE HABIT, ICE-CREAM HABIT, PEPSI COLA HABIT, JOY RIDING, TRIPPING.

CIBA: Doriden, nonbarbiturate sedative, made by Ciba Company. D., C.B.

CLEAN: no drugs on person when arrested; free of all drugs. Pot without seeds or stems (MANICURED).

COCAINE: COKE, SNOW, HAPPY-POWDER, CHARLIE, HAPPY-DUST, POGO-POGO, C-DUST, STARDUST, BOUNCING POWDER, GIN, BIG-C, CANDY, BERNICE, CHOLLY, GIRL, GOLD DUST. GOOFY DUST--powdered cocaine for snorting.

CODEINE: POP, SCHOOLBOY, TURP.

COKED-UP: under the influence of cocaine.

COKE HEAD: user of cocaine (LEAPER).

COMBINATIONS: mixtures of two or more drugs. At present the usual basic ingredient is LSD to which is added any of the following contaminants: speed, sernyl, heroin, opium, strychnine, cocaine, atropine, belladonna, strammonium, STP, DMT, mescaline, etc. Also called SALADS. Their composition is usually unknown and even street names don't indicate ingredients. Following are current street names of these mixtures (some may be pure acid but it is impossible to tell now). Pure ones are RIGHTEOUS and adulterated ones are DIRTY, SALADS, COMBINATIONS. Blue haze, blue cap, green swirl, purple tab, black flat, green dot, purple haze, black acid, yellow flat, brown dot, blue splash, orange sunshine, orange blossom, orange wedge, strawberry field, strawberry acid, red dimple, orange double dimple, blue smear, paper acid, love, love saves, white lightning, peace pill, LBJ stay away, product IV, cupcake, greendome, let sunshine do, purple ozoline, purple barrel, grape parfait, peppermint swirl, yellow (pink, orange, purple) wedge, yellow dimple, blue cheer, blue flat, blue doubledome, chocolate-chip, orange dome, orange double dome, double dimple, squirrel. quicksilver, Hawaiian sunshine, California sunshine, clear dot, purple microdot. See LSD.

COME DOWN: return to normal state after being high on a drug; lost effects of a drug. COME HOME, LAND, SOBER UP.

COME ON: start to get effects of a drug.

COMMUNE: group with similar philosophy and life style living together and supporting each other. ENCLAVE.

CON: to fool, deceive or swindle. BEAT, FLIM-FLAM.

CONTACT HIGH: turning on by coming in contact and interacting empathetically with someone already high on a drug; becoming high from being in a small unventilated room where pot is being smoked without actually smoking it.

COOL: smart, knowledgeable in ways of drug scene, etc.; safe. GROOVY.

COOL IT: stop what you are doing.

COP: acquire, take, buy, steal.

COP TO: admit to something. COP OUT TO.

COP OUT: give up, drop out of drug scene, society, etc., avoid a situation.

COP OUT ON:	fail to do something.
COPE:	handle self effectively while high on a drug or otherwise.
CORAL:	chloral hydrate (non-barbituric sedative). JOY JUICE. Also see MICKEY FINN.
CRACK A BENNIE:	crack open benzedrine inhaler (or other type) to get drug impregnated wick for use.
CRANK BUGS:	imaginary insects on skin while speeding.
CRANKING:	using speed (CRANK) repeatedly. SPEEDING.
CRASH:	enter somebody's apartment or pad to sleep; fall asleep; come down hard from a high.
CRASH PAD:	facility run by non-professionals to treat bum trips by talking-down method. Street level operation to care for trippers right off the street without hassling them or informing authorities, either parental, academic, or police. A crisis center for the care of bummers.
CRAZY:	enjoyable, exciting, great.
CROAKER:	doctor who sells illegal drugs or writes prescriptions for them. HACK.
CRYSTAL PALACE:	place where speed (amphetamine) is shot (injected).
CRYSTALS:	speed in powder form.
CYCLAZOCINE:	narcotic antagonist being tried for heroin addiction. CYC.
CRUMBS:	money (small change).
CUFF:	stand somebody up.
CURE:	speed up maturing of plants which yield drugs by moistening with sugar water or wine and then slowly drying them.
D:	Doriden (non-barbiturate sedative). CIBA.
DABBLE:	to take small amounts of drugs on an irregular basis.
DARVON:	non-opiate analgesic abused by some. PINKS, RED & GRAYS.

DEMEROL:	synthetic opiate which has replaced morphine due to fewer side effects. Does not constrict the pupils. Favorite drug of addiction by doctors and nurses rather than heroin. MEPERIDINE, PETHIDINE.
DESTROY:	ruin, smash.
D.E.T.:	variant of D.M.T.
DHARMA:	right to do; a proper way of life for an individual.
DIG:	to enjoy, appreciate, understand.
DIGGERS:	hippie group which gives aid to other hippies (i.e., providing food, etc.).
DILAUDID:	opiate stronger than morphine with fewer side effects. Effective by mouth as well as by injection. DILLIES.
DILL:	a plant of the parsley family alleged to produce mild stimulation and euphoria. See Z.N.A.
DIPPIE:	former hippie who dropped out of movement and into straight society.
DITRAN:	piperidyl benzilate. A potent hallucinogen producing catatonia, auditory hallucinations and psychoses. J.B.-239.
D.M.A.:	a synthetic amphetamine.
D.M.D.A.:	synthetic amphetamine.
D.M.T.:	dimethyltryptamine. Very short acting (30') hallucinogenic drug related to LSD but milder. Easily synthesized and similar to psilocin. Parsley soaked in it and then eaten or smoked. Known as the BUSINESSMAN'S PSYCHEDELIC MARTINI or BUSINESS MAN's TRIP. COMMUTING -- taking D.M.T. See also D.E.T., D.P.T.
DOLLS:	barbituates and amphetamines (from "Valley of the Dolls").
DOLLY:	methadone, a synthetic opiate used in heroin withdrawal and addiction. DOLOPHINE, METHADONE. Synthesized in the Third Reich and named Dolophine after Adolph Hitler.
D.O.E.:	synthetic amphetamine.

D.O.E.T.: synthetic amphetamine which is analog of S.T.P. and very potent.

DON'T SWEAT IT: don't fret, take it easy.

DON'T TREAD ON ME: don't lay your thing on me. Don't force me.

DOWNER: tranquilizer or barbiturate. BACKWARDS.

DO YOUR THING: doing what one enjoys; doing what one feels is right or necessary for one's happiness or peace of mind.

D.P.T.: variant of D.M.T.

DRAG: dull. A boring event, thing or person .

DROP IT: say it.

DROP OUT: withdraw from a disliked activity.

DRUG SCENE: the varied activities and actions related to drug users and their life style. STREET: the user's environment, his neighborhood or his milieu. Also referred to as NARCOLAND and LIVING ON THE BRICKS or LIVING ON THE STREET. (For specific drugs, consult appropriate headings in glossary).

MARKETING:

BIG MAN: top person in drug ring. SOURCE.
JOBBER: one who stores drugs in bulk for distribution.
PUSHER/DEALER: sometimes distinction made that pusher deals only in hard drugs and dealer in soft drugs. PEDDLER, CANDY MAN, CONTACT, CONNECTION, ICE CREAM MAN, PAPER BOY, MOTHER, SUPPLIER, BAG MAN, TAMBOURINE MAN , BROKER, SOURCE, TRAVEL AGENT, TRAFFICER, JUNKER, SWINGMAN, BIG MAN, COP MAN.
COYOTE: tricky or dishonest seller.
SNATCH-GRAB JUNKIE: unreliable small-time pusher.
RUNNER: transporter of drugs from source to pusher. MULE, CONDUCTOR ON TROLLEY.
MAKE A RUN: travel to another city to obtain drugs.
GLOBETROTTER: one who contacts all local pushers in effort to get the best stuff.
ARSENAL: pusher's supply of drugs. CARGO.
STASH: hidden supply of drugs. CACHE, PLANT.
SQUIRREL: addict who stashes large amount of drugs.
THOROUGHBRED: sells only pure drugs. TAKE OFF ARTIST: steals from other addicts or pushers.

Manufacture and Processing:

FACTORY: clandestine lab for making drugs. BREWERY, MIDNIGHT LAB, KITCHEN LAB, FEED STORE, LAB.
COOK: chemist who works in a clandestine lab.
CAP: drug sold in gelatin capsule. CAPSULE, BEAN.
CAPPING: process of putting drug in capsule. PUT UP.
DOTTING: dropping liquid drug as acid on porous paper.
TABBING: placing liquid drug on tablet such as acid on vitamin C tablet.
TAB: tablet. PILL.
DUSTING: sprinkling powdered drug on another substance as dusting PCP or HOG on parsley or DMT on grass.
CUTTING: diluting down drug with another substance which may be inert as milk sugar, talc, starch or active as quinine, quinidine, procaine, histadyl. WACK UP.
STRETCHER: material used for cutting. FILLER.
WEIGHT: amount of drug. HEAVY: large amount. LIGHT: small amount.
ROLL: roll of tablets in foil or paper. ROLL DECK.
BOTTLE: large number pills or tablets such as 1,000. JAR, JUG. BOTTLE OR JAR DEALER.
KEG: very large number tablets, pills or capsules as 25,000.
FEED BAG: container for drugs.
BIZ: small amount of drug.
PIECE: unit of measurement of drugs. For various names see sections on heroin, speed and marihuana elsewhere in glossary.
PILLOW: sealed polyethylene bag of drugs.
TASTE: tiny amount of a drug offered as inducement to purchase as a sales promotion gimmick. PICK UP.
BAG, BINDLE, BALLOON, FOIL, SPOON, DECK, ETC. (See under Heroin).
WRAP: wrapping of paper, foil or plastic used to disguise package of drugs and to obliterate the odor.

Quality control (or lack of it):

RIGHTEOUS: pure, unadulterated drugs. HONEST, PURE.
COUNT: quality or purity of a drug.
BURNED: cheated in drug purchase, i.e., drug not righteous due to additives or fillers or very weak due to excessive cutting.

(continued on next page).

BURN ARTIST: dishonest seller, i.e., poor quality as above or no delivery after payoff.
PUFF: to extol a drug as being better than it actually is, i.e., purer, stronger.
FRUIT SALAD: pooling of various drugs removed from home medicine chests. Participants then take them without any knowledge of what they are using. GRAB BAG, POT LUCK.
SALADS: combinations of drugs. See COMBINATIONS elsewhere in glossary.

Drugs in general: (For specific drugs refer to glossary).

DOPE: any drug (originally referred to cocaine and opiates only). STUFF, GOODS, MERCHANDISE, CANDY, SUGAR. GOOD STUFF: high quality drugs.
STONEHEAD: person dependent on a drug. LEANING ON DRUGS.
DOPER: one who takes drugs of any sort. USER, DRUGGIE, PLAYER. (See also other section on ADDICT/ADDICTION.)
DOING DRUGS: taking drugs. INTO, BEHIND, USING, ON, GETTING ON,
DOPE FIEND: originally restricted to one dependent on morphine or cocaine. Now refers to user of any drug.
HEAD: chronic user of a drug, i.e., POTHEAD, ACIDHEAD, PILLHEAD, etc.
MIND BLOWER: unusually pure drug. One that is honest or righteous.
SMALL TIME: refers to drugs other than heroin. SMALL STUFF, LIGHT STUFF.
BIG TIME: refers to heroin and cocaine. HEAVY STUFF.
SOFT DRUGS: poor term referring to drugs that do not cause physical addiction (may produce psychological addiction, however). Included are pot, speed, acid, etc. LIGHT STUFF, HEAD DRUGS.
HARD DRUGS: equally undesirable term usually thought to refer to drugs capable of resulting in true physical addiction. Besides heroin and other opiates barbiturates and minor tranquilizers could be included as they lead to physical addiction. Cocaine included in hard category by some even though it produces psychological rather than physical addiction. HEAVY STUFF, BODY DRUGS.
MIND BENDER: drug said to expand the consciousness or mind, i.e., hallucinogen as LSD, etc.
TURN ON: to start somebody on drugs.

Methods of use and condition of users:

POP: take by mouth. DROP, PILL DROPPER, PILL POPPER.
PILLHEAD: chronic user orally.

SNORT: use nasally like snuff. SNIFFING, HUFFING, HORNING.
MATCHEAD: small amount employed for
MUSCLE: to inject intramuscularly.
SKIN POP: subcutaneous injection. POPPING, SKINNING
MAINLINE: inject intraveneously. LINING, SHOOTING, FIXING.
TONGUE IT: to inject in floor of mouth at base of tongue to escape detection .
SHOOTERS: mainliners.
SHOOT UP: a series of injections repeated within short period of time as speed, cocaine.
RUN: series of injections repeated over a period of several days without any respite as with speed, cocaine, etc. Longer duration than a shoot up. BINGE.
RUSH: Initial pleasureable sensation following shooting heroin, speed, etc. FLASH, JOLT, ZING, TINGLE, THRILL, SPLASH, CHARGE, KICK.
SPREE: long period of steady use of drugs or alcohol.
BADS: post spree or post run depression. LIFT: respite from BADS.
STONED: under influence of drug or intoxicated from drug. CHARGED UP, RIPED, HIGH, LOADED, BLOCKED, LIT UP, BLASTED, TWISTED, FLYING. UP, BELTED, GROUND UP, TORN UP, COASTING, GOING UP, TAKING A TRIP, ZONKED, SPACED, SPACED OUT, FLOATING, HOPPED UP, BLITZED, WIRED, LOADED, JACKED UP, BENT, BENT OUT OF SHAPE, BOMBED, BOXED, KNOCKED OUT, MESSED UP, MONOLITHIC, OUT OF ONE'S MIND, SPIKED, WINGING, SMASHED, BENDING AND BOWING.
WASTED: so deeply under influence of drug from repeated use that one no longer can function normally. DESTROYED, SPENT, WIPED OUT, WHIPPED, BEATEN. Exhausted physically and ruined psychologically.
STONEHEAD: one completely dependent on drugs. LEANING ON DRUGS.
WASHED UP: off drugs. WITHDRAWN, CLEAN, CLEARED UP, CLEAN HEAD, CLEANED UP, GOOD HEAD.
STRAIGHT: not intoxicated or under influence of drugs. Also means feeling well or not sick for lack of a fix.
LAUNCHING PAD: place where drugs are taken in a group. SHOOTING GALLERY, PAD, ACID PAD, FREAK HOUSE, FLASH HOUSE.

Buying drugs:

MEET: appointment for copping drugs. PICK UP: obtain drugs from somebody.
IN POWER: having drugs to sell. SLICE BREAD: make payoff.
SCORE: to buy drugs. COP, CONNECT, HIT, MAKE, MAKE BUY, MAKE THE MAN, MAKE STRIKE.
SHORT COUNT: small amount sold as a larger amount.
DEAL IN WEIGHT: sell large amounts. HEAVY DEALING. SCRATCHING: searching for drugs.
PUT OUT FIRST: pay in advance with delivery later. SPOT YOU.
HAND TO HAND: person to person delivery drugs with payment at the time.
BUY: evidential purchase by agent or by informer under supervision of agent.
BURNED: cheated in a purchase. BURN ARTIST: dealer who specializes in burning people.

DUDE: any male.

DUSTED: under influence of P.C.P.

DYKE: female homosexual, lesbian.

DYNAMITE: a great event, thing or happening. OUT OF SIGHT. Also potent, uncut heroin.

EGO GAMES: deprecatory term applied to social or business activities of the square world.

EGO TRIP: actions that bolster one's own ego irregardless of their possible harmful effects on others.

ELECTRIC: exciting, scintillating, mindblowing. Influenced by or containing a psychedelic drug as in electric kool-aid.

ELECTRIC KOOL-AID: punch containing LSD frequently served at Acid Tests.

ESTABLISHMENT: those of you who are over 30 years old and members of the decadent menopausal generation that is not to be trusted. Welcome to the group! NEW ESTABLISHMENT: young adults just turning 30 and so just out of the youth and/or drug subculture.

EXPLORER'S CLUB: circle of acid users.

FAG: male homosexual. FAGGOT, GAY, FAIRY, FRUIT.

FAKE OUT: to fool.

FALL OUT: falling asleep. ON THE NOD, CRASH, FLAKE OUT.

FAR OUT: bizarre, unusual, avant-garde. WAY OUT.

FEED YOUR HEAD: take drugs.

FEED YOUR MONKEY: maintain a drug habit, especially heroin.

FEMME: lesbian who plays role of female.

FINK: one who gives information to the authorities or gives up to the establishment.

FINK OUT: to inform, fail to do something. RAT, SNITCH.

FIREPLACE RITUAL: verbal dressing down in presence of all residents. Synanon term.

FIX: injection of drug, usually heroin. JOLT, SHOT, JOB, GEEZE, CHARGE, WAKE-UP.

FLAKY: a little abnormal mentally or emotionally but not really psychotic.

FLAMING: adjective to intensify meaning of a noun, i.e., flaming chick. SCREAMING.

FLAP: fuss or commotion about something.

FLASHBACK: recurrence of drug reaction (acid, pot) weeks or months later without taking drug again. RECURRENCE, ECHO, FREE TRIP, RETURN TRIP.

FLIP: express unusually strong emotion; exhibit psychotic behavior; to become unduly excited or psyched up.

FLIP OUT: to have psychotic reaction to drug; lost control or develop anxiety. To have a mystical experience through drugs, yoga, meditation, etc. WIG OUT.

FLOWER CHILDREN (PEOPLE): youths who have dropped out of conventional society and practice free love, free drugs, free food, communal living, etc. They seek God, peace, love, nonmaterialism and noncompetitiveness. Not all of them necessarily use drugs.

FLOWER POWER: use of love rather than force to effect change in man and society.

FLUNK OUT: to start using stronger drugs than formerly. GRADUATE.

FLY AGARIC: hallucinogenic mushroom containing bufotenine.

FOURS: number 4 empirin compoung (1 grain codeine).

FRACTURE: to shake up or disturb.

FRANTIC: nervous, jittery, desperate.

FREAK: one who uses a drug intensely (i.e., speed freak, acid freak, freon freak). Also one intensely interested in non-drug activity (i.e., car freak).

FREAK HOUSE: where speeders congregate to shoot. FLASH HOUSE.

FREAK OUT: lose contact with reality; wild or unusual behavior; have fun; change something radically, become temporarily deranged from a drug. Also to surprise or alarm (i.e., freak out my parents).

FREAKY: weird, strange.

FREON: a refrigerant. Also used as a propellant for many aerosols. Intonicating and it may produce asphyxiation or cardiac irregularities when inhaled. Sometimes fatal -- the S.S.D.S. (SUDDEN SNIFFING DEATH SYNDROME).

FREON FREAK: user of freon. FROST FREAK.

FRINGIES: non-students who hang around students or hippie groups without actually being part of the group.

FRISCO SPEEDBALL: cocaine, LSD, and heroin.

FRONT: false display of respectability (not genuine) as conventional clothing being worn by hippy for effect on the establishment. Also lending money for a purchase.

FROSTY: exceptionally knowledgeable and cool (almost to a point of being unapproachable). The acme of coolness. SUPERCOOL.

F.U.K.: hallucinogenic drug, possibly a form of S.T.P.

FLUNKY: distasteful and unattractive. Occasionally really neat or great depending on the attitude of the person.

GAME: conventional attitude or behavior; order of structured society; group therapy session (Daytop, Synanon, etc.).

GARBAGE HEAD: one who will take any drug offered without knowing or caring what it is.

GAS (GASSER): supreme or super experience; unusually pleasing thing.

GASSED-OUT: overcome by unusual experience be it amusing, beautiful, exciting, etc.

GERONIMO: drink of alcohol with barbiturates.

GET BEHIND IT: enjoy a high. Become completely involved in the action at hand.

GET IN THE WIND: ride a bike (motorcycle).

GET UP: to take drugs and notice an effect. GO UP, TAKE OFF, LIFT UP, GET OFF.

GIG: originally a performance by a musical group. Now a job, profession, or any activity.

GLOW: pleasant feelings from taking a drug.

GLUE-SNIFFING: inhalation of any volatile solvent that intoxicates as quickly drying glue, carbona, turpentine, gasoline, nail polish remover, freon, etc. (GASSING, HUFFING, BLOWING THE BAG, FLASHING). GLUEY: one who sniffs glue. (GLUEHEAD). WAD or GLAD RAG: cloth saturated with solvent and held to nose for sniffing. See FREON.

GETTING ON: taking drugs. USING. GOING-UP.

GOOD PEOPLE: a person who is all right; one who can be trusted with drugs or otherwise.

GOOF: make a mistake, take drugs.

GOOFED UP: under the influence of goofballs (barbiturates), originally; now includes pot, etc.

GOOFING: behavior in unusual or drunk fashion after taking goofballs; the playing of mind games when stoned.

GOOF-OFF: not to do a job; do something without a purpose.

GO STRAIGHT: get off drugs. To refrain from all illegal activities.

GRAB: to impress, appeal, suit (i.e., "How does that grab you?").

GRAVOL: hallucinogenic antihistamine used in Canada and England.

GREASER: formerly derogatory term for Mexican-Americans, Mexicans, etc. Now applied to one you don't like or respect regardless of color, race, etc.

GROSS: repulsive, crass, undesirable.

GROOVE: concentrate intensely on an object or activity with great pleasure (i.e., grooving on grass).

GROOVY: swinging, with it, great, extremely enjoyable. GASSEY, OUT OF SIGHT, WIGGY.

GROUNDMAN: one who remains straight during an acid party to care for the trippers. BABY SITTER, GUIDE, TOUR GUIDE, CO-PILOT, GROUND CONTROL.

GURU: Hindu teacher, hippie leader, one whose ideas or philosophies are greatly admired or esteemed.

GUT LEVEL: deep emotionally.

HACK IT: to tolerate something , to cope with a situation. CUT IT.

HAIRCUT: Daytop Village or Synanon term for severe verbal reprimand given to erring member of family by one of the older members. If offense is severe enough his head may be shaved in addition to the dressing-down.

HAIRY: difficult, rough.

HANG IN THERE: stay with it, keep strong. HANG TOUGH.

HANGUP: uncomfortable idea or habit, thing that is bugging one.

HANG LOOSE: stay calm and relaxed.

HAPPENING: the action at the moment; meaningful event.

HARMINE: hallucinogenic alkoloid from South American vine. May be fatal.

HASHBURY: contraction of words HAIGHT-ASHBURY.

HASHISH: see marihuana. HASH.

HASSLE: argument; unpleasant situation. Verb means to bother, annoy, argue.

HEAD: chronic user of drug, for example, acidhead (LSD), pothead (marihuana), A-head (amphetamines).

HEAD SHOP: store specializing in items of interest to the drug subculture.

HEAD SHRINKER: psychiatrist. SHRINK, PSYCH.

HEAT: police pressure, administration pressure (school) or pressure from any other source.

HEAVY: important, impressive, significant. A strong drug, for example, heavy grass. Doing a lot of something as heavy dealing of drugs (HEAVY INTO DRUGS).

HEIFER DUST: baloney; b.s. JIVE, BULL.

HEROIN: MAINLINING, ADDICTS and ADDICTION, OPIUM. (See also these headings elsewhere in glossary).

JUNK: heroin. H, HORSE, HARRY, SCAG, SMACK, WHITE STUFF, GOODS. MERCHANDISE, POISON. ANTIFREEZE, SCAT.

MAINLINING: intravenous injection. LINING.
POPPING: subcutaneous injection. SKIN POPPING, SKINNING, POPPING.
SNORTING: nasal use like snuff. SNIFFING, BLOWING, HORNING.
BREAKING IN: just commencing to use junk. CADET: novice junkie.
HONEYMOON STAGE: period of early use before addiction. VIRGIN STATE.
HEAVY, DYNAMITE, BOMB DYNO: strong heroin.
GARBAGE, LEMONADE, LIPTON TEA, FLEA POWDER, CRAP: weak junk.
BLANK, TURKEY, DUMMY: alleged heroin but none present in the powder.
HOT SHOT, RAT POISON: heroin purposely poisoned with Ajax, rat poison, strychnine, etc.
CUTTING: diluting before sale by adding inert substances as milk sugar, starch, talc, and sometimes active ingredients as quinine, quinindine, histadyl, procaine.

STRETCHERS, FILLERS: substances as sugar, quinine, etc., used for cutting heroin.

BAD BUNDLE: package of heroin ruined by moisture or excessive cutting.

Quantities for sale:

DEUCE: $2 bag. TRES: $3 bag. NICKEL Bag: $5 worth. DIME BAG: $10 worth. EIGHT: 1/8 ounce. QUARTER: 1/4 ounce. PIECE: 1 ounce (CAN). HALF LOAD: 15 bags. BUNDLE: 25 bags. KEY: 1 kilogram (2.2 pounds). CAP: capsule of heroin. GRAM: 10 caps. BUNDLE, PACKET, DECK, PAPER: folder paper or glassene envelopes of junk. FOIL: tinfoil packet of heroin. BIRD'S EYE: tiny amount. BALLOON: toy balloon containing heroin.

BROWN STUFF: heroin from Mexico, etc., that is brown. BROWN.

CHINA WHITE: heroin from Europe, etc., that is white. WHITE.

RED CHICKEN: Chinese heroin.

RUMP: to be on junk. IN THE BIG TIME.

HIP: aware; in the know; informed; tuned-in.

HIPPIE: dropout from society who refuses to accept and adopt the values and mode of life of the Establishment.

HIT: arrest; rob; purchase drugs; find a vein; smoke a joint; one dose of a particular drug.

HIT THE MOON: achieve the highest point of a trip. PEAK, REACH FOR THE MOON.

HOLDING YOUR MUG: keeping a secret.

HOOKER: whore.

HORN: the telephone. Inhale drug through the nose (Snort, Sniff).

HORROR DRUG: one of the belladonna alkoloids.

HOT SEAT: chair in which member of Dayton Village or Synanon is seated during encounter therapy for infraction of rules.

HUNG UP: vacillating without being able to reach a decision. Involved with person or thing to exclusion of everything else.

HUSTLE: pursue women, money, drugs or fame. Work hard to accomplish something. To obtain money for drugs by thievery, prostitution (TURN A TRICK), PIMPING, etc.

HUSTLER: one who hustles; a go-getter.

HYDROCODONE: synthetic codeine. DIHYDROCODEINOWE, HYKE, HYCODAN.

IFIF: International Foundation Foundation for Internal Freedom founded by Leary for experimenting with LSD, mescaline, etc.

IN: belonging to or accepted by a group.

INHALERS: glue and other volatile solvents (deliriants). Also nasal inhalers as wyamine. (See GLUE SNIFFING and FREON).

INNER SPACE: one's innermost self; physical recesses of mind believed affected by drugs.

INTO: being involved in (i.e., "He is into acid now."). BEHIND.

IN TRANSIT: on an acid trip.

JAMMING: to blow your cool, at a loss for words.

JAZZ: small talk. JIVE.

JIVE: to lie or cheat. As noun--unimportant talk, lies, baloney (BULL), GARBAGE (JAZZ, ROUND AND ROUND).

JOHN: person who does not use drugs. Client of prostitutes.

JOINT: marihuana cigarette. STICK, REEFER.

JOY POPPING: intermittent use of heroin for kicks or tripping without being addicted.

JUICED: high on alcohol. JUICED UP, BOMBED, SMASHED.

JUICEHEAD: alcoholic.

KARMA: alleged aura, radiations or vibrations given off by a person. May be good or bad. Also one's life as determined by fate.

KEEP THE FAITH BABY: phrase used when splitting.

KEEP THE LID ON: control or contain things.

KEEP IT ON ICE: to keep a secret.

KINK: a hang up, a particular habit or activity one has to indulge (i.e., a homosexual has to do his thing eventually).

LAY IT ON: attempt to force your thing or thinking on another; forceful arguing.

LAY IT ON ME: tell me all about it without holding back.

LAME: un-hip, not street-wise, subscribes to middle and upper-class morality. STRAIGHT, SQUARE.

LAND: come down easily from trip. COME HOME.

LEAN ON: to apply pressure (heat) of any kind.

L.B.J.: a piperdyl compound which is hallucinogenic. Not the same as L.B.J. Stay Away. J. B.-336 and T.W.A.

LEGAL HIGH: trip from over-the counter item not requiring a prescription such as Amyl nitrite, Sominex, Contact, etc. (See NATCH TRIP).

LEMAR: group advocating the legalization of marihuana.

LET IT ALL HANG OUT: level with somebody, speak freely hiding nothing.

LET IT SLIDE: to ignore something.

LIKE: filler word for pauses in conversation when hesitating.

LIPPIE: a hippie preoccupied with putting down straight society through debate, activism, etc.

LOOSE: relaxed.

LOOSE IN THE HEAD: disturbed mentally or emotionally. FLAKY.

LOSE ONE'S WIG: lose one's mind, become flaky.

LOSE YOUR COOKIES: vomit after taking drug. DUMP, FLASH, HEAVE.

LSD: League for Spiritual Discovery, a "religion" founded by Timothy Leary and using LSD, mescaline, etc., as sacrament.

LYSERGIC ACID: chemical precursor of LSD used in its manufacture. Not hallucinogenic itself. Illegal to buy now.

L.S.M.: chemical cogener of LSD.

LSD: ACID, CUBE, 25, BIG D, HAWK, CHIEF, BLUE, OWSLEY, GHOST, WHITE SANDOZ, CUBE, BEAST, CRACKER, COFFEE, etc.
Hallucinogenic derivative of lysergic adic, an alkaloid found in the rye fungus ergot (Claviceps purpura). Chemical name of LSD is d-lysergic acid diethylamide tartrate 25.
LSD -- "love, security and devotion".
See COMBINATIONS for street names.
ONE WAY HIT: single tablet for one trip. SINGLE HIT.
TWO WAY HIT: single scored tablet with trip two people (i.e., double blue dome). DOUBLE HIT.
FOUR WAY HIT: tablet which is double scored so it can be broken into four parts. Micrograms sufficient so that four people can get off.
PAPER ACID: PAPER, LOVE SAVES, BLUE SPASH, BLUE DOT, RAGGEDY-ANNY, SKY-RIVER, GELATIN FLAKE ACID: WINDOW GLADD, CONTACT LENS, CLEAR LIGHT. (See Combinations for street names).

M99: etorphine. Very potent opiate for animal use only.

MACE: spice derived from nutmeg and slightly hallucinogenic due to mysticin (elemincin). Also a repellant aerosol used as a defensive weapon in law enforcement.

MADE IT: attained one's goal.

MAINLINING: (See also headings elsewhere in glossary as HEROIN, SPEED, ADDICTS AND ADDICTION.
Intravenous injection of junk. LINING, BANGING, SHOOTING, JABBING, JOLTING, SPLASHING, TAKING OFF, GETTING OFF, GEEZING, DRILLING, HITTING.
DITCH, VALLEY: inside of elbow which is favorite site for shooting. Other locations used include forearms, legs, between toes and fingers, tops of hands and feet, neck (external jugular vein), floor of mouth at base of tongue (lingual veins) and penis (dorsalis penis vein--rarely used).
PIPE: large good vein for hitting. ROLLER: large vein that rolls away from needle.
TRACKS: needle marks and scars from mainlining. CRATERS, MARKS CORNS.
TRACKED UP. arms or legs covered with TRACKS. LOUSED UP.
POCKS: depressed oval scars from skin popping. POCK MARKS.
PAD, SHOOTING GALLERY, CRYSTAL PALACE: place where junkies shoot in.

(Continued on next page).

GIVE WINGS: teach one how to mainline. CADET: Novice junkie.

WORKS: equipment for mainlining. KIT, ARTILLERY, MACHINERY, TOOLS, GIMMICKS, BIZ, LAYOUT.

SPIKE: needle (NAIL, POINT). GUN: syringe or eyedropper (DRIPPER, MACHINE).

SILVER BIKE: syringe with chrome fittings. MOBY GRAPE: syringe or dropper with rubber bulb from baby's pacifier.

COLLAR: tape or rubber band to improve fit between hub of needle and end of syringe or dropper. GASKET.

COOKER: spoon or bottle cap for heating heroin and water.

COOK: dissolve heroin in water by heating (PAN UP).

HOCUS: mixture ready for shooting.

SATCH COTTON: cotton in spoon or bottle cap for filtration before shooting up.

TIE: tourniquet (silk stocking, bow tie, belt, etc.).

TIE UP: apply tourniquet (DO UP).

HIT: to inject vein. BLOW: to miss vein (MISS).

REGISTER: aspirate to make certain in vein. BACK UP, BACKTRACK.

TAP: inject very slowly by tapping end of syringe or dropper with finger.

BOOTING: sequence of repeated aspirations followed by repeated injections to prolong effects. JACKING.

SHOOTING GRAVEY: dissolving dried residue of heroin and blood in syringe or dropper by heating it. This can then be shot again.

COTTONHEAD: one who cooks up several satch cottons to obtain what little heroin is trapped in the fibers in order to get another fix. COTTON TOP.

MAINTAINING: keeping self at a certain level of drug effect and being able to function properly.

MAKE IT: achieve something; inject a drug; buy a drug; to be with it.

MAKES IT: something that is just good or merely acceptable but not out of sight or dynamite (i.e., "That song makes it but it's not out of sight.").

MAKE THE SCENE: go where the action is.

MAKE TRACKS: to split. To leave tracks on body from shooting.

MAN: general term for addressing a male in conversation; a narcotic agent.

MANDALA: Hindu mystic symbol (often worn around neck).

MANDREX: combination of pyribenzamine and quaalude shot in England.

MARATHON ENCOUNTER: Daytop Village term for prolonged 14-48 hour encounter group therapy session held periodically.

MARIHUANA: POT, GRASS, TEA, HEMP, CANNABIS, ROPE, HAY, WEED, MARY JANE, GUAGE, MUGGIES, GANGSTER, BUSH, TEXAS, TEA.
STICK: cigarette. JOINT, REEFER (old term), ROCKET, HAPPY CIGARETTE.
PIN: thin joint. BOMB: thick joint (THUMB). PANATELLA: large long joint.
COCKTAIL: conventional cigarette in end of which is deposited some grass or hash.
CANCELLED STICK: conventional cigarette emptied and refilled with marihuana.
ROLLING UP: making a joint.
SKIN: general term for paper used in making sticks. PAPER. Specific papers used include, among others, BAMBOO, ZIGZAG, TOP (pot backwards).
ROACH: but of joint. SNIPE.
CRUTCH: holder for smoking roach so as not to burn fingers. BRIDGE, CLIP, AIRPLANE, JEFFERSON AIRPLANE.
BLOWING GRASS: smoking marihuana. SMOKING, GOOFING, TAKING UP, TOKING UP, FIRING UP, BLOWING A JOINT, BLASTING, GETTING ON, TAKING GIGGLE SMOKE, POKING, PICKING UP, LIGHTING UP, BLASTING A JOINT.
POTHEAD: regular smoker. TEAHEAD, GRASSHOPPER, YOUNG BLOOD (Novice).
POT PARTY: group smoking. BLAST PARTY, TEA PARTY.
TUCK AND ROLL: fold ends of joint rather than twisting them.
SCARF A JOINT: swallow stick or roach to escape detection.
MUNCHIES: urge to eat (especially sweets) after smoking. HUNGRIES, PEPPERMINT CANDY JAG.
TOKE PIPE: marihuana pipe. HOOKAH, HUBBLY-BUBBLY: water pipes.
STEAMBOAT: joint stuck in hole cut in top of cardboard core of toilet paper roll.
ENLIGHTENED COOKING: use of marihuana in cooking. COOKING WITH GRASS INSTEAD OF GAS. POT LIKKER: beverage of conventional tea plus marihuana. GRASS BROWNIE (ALICE TOKLAS BROWNIE), GRASS MUFFINS, GRASS BREAD, GRASS SPAGHETTI SAUCE, APPLE TURN-ONS, CHILI POT, HOT POT FUDGE, GRASS SALAD, GRASS MEAT BALLS, etc.
SHOT GUN: holding lit end of joint in mouth and blowing smoke through it into mouth of another person.
BOGART A JOINT: letting stock dangle from lips in manner of late Humphrey Bogart; taking too long with joint before passing it to your neighbor. BOGART, HOG A JOINT.

(Continued on next page).

Types of Marihuana:

Foreign: BHANG: weakest. GANJA, KIF, DAGGA: intermediate. HASHISH (HASH) and CHARAS: most potent of all is made from the resin and so is 5 to 8 times as strong as ordinary street grass. BLACK RUSSIAN: hashish. GOLD LEAF: general term for foreign pot which is stronger than native grass. Examples of foreign marihuana include: CAMBODIAN RED, PANAMA RED, AFRICAN BLACK, PANAMA GOLD, CANADIAN BLACKY, TIAJUANA GREEN, ACAPULCO GOLD, MIHOACAN, MEXICAN GREEN, BLUE DIRT.

Native: (American): MANHATTAN SILVER: rumored to be grown in sewers without sunshine and consequently pale in color (probably a put-on). Current varieties include ILLINOIS GREEN, CHICAGO GREEN, BETHESDA GOLD, TENNESSEE BLUE, KENTUCKY BLUE, etc., and are less potent than foreign marihuana. O.J. (OPIUM JOINT): stick to which opium has been added. HEAVY GRASS: unusually strong pot (GOLD, GOLD LEAF, SUPERPORT). TRIP GRASS: marihuana to which has been added speed, DMT, opium, herion, etc. (SALT AND PEPPER). ICEBERG: marihuana added to iceburg lettuce. ICE PACK: high quality grass (ICE BAG). PURPLE SEEDLESS: specifications unknown but rumored to be heavy grass.

Processing and Marketing:

DIRTY: contains seeds, stems and leaves. UNMANICURED, ROUGH, ROUGH STUFF.
CLEAN: refined grass from which stems and seeds have been ewmoved. MANICURED.
SHORT: loosely packed. LONG: tightly packed.
BRICK: a kilogram. KG, KEY. BALE: 50 to 100 pounds of compressed grass.
L.B.: pound. BAR: compressed block of pot not as large as bale.
LID: one ounce. Originally Prince Albert tobacco can was used. CAN.
BOX: about 1/5th of an ounce of lid (can). Formerly the amount contained in old-fashioned penny match box.
NICKLE BAG: $5 worth or about 1/4 of an ounce.
DIME BAG: $10 worth or approximately 1/2 ounce.
SOLE: flat rectangular piece of hash.
STOCK: large number of joints.

T.H.C.: tetrahydrocannabinol. Also called SYNTHETIC GRASS. One of the active ingredients of marihuana which can be extracted from the plant and more recently has been synthesized in the laboratory. Tablet and liquid preparations are available. Since it is notoriously unstable, all the THC or SYNTHETIC GRASS sold on the street invariably is something other than THC -- presently most of it appears to be P.C.P. It is produced legitimately for research. See PARAHEXYL.

MARK: one easily conned or tricked.

M.D.A.: synthetic amphetamine; 3, 4-methylenedioxyamphetamine which is a potent hallucinogen. LOVE PILL.

MEAN: exceptionally good, almost perfect.

MELLOW: happy. Pleasantly high--not too far up and not too far down.

MELLOW-YELLOW: dried banana fibers for smoking. Alleged to be hallucinogenic but a put-on.

MESCALINE: hallucinogenic alkaloid extracted from peyote cactus or synthesized in laboratory. Stronger than pot but weaker than acid. Yields same effects as peyote but there is less nausea and vomiting. MESC., PUMPKIN SEEDS, YELLOW FOOTBALLS, YELLOW SUBMARINES, STRAWBERRY MESC.

MESS AROUND: do something inconsequential for the hell of it. GOOFING.

MESS UP: make a mistake. FOUL UP, GOOF UP.

METHADONE: see DOLLY.

METHAPYRILINE (HISTADYL): filler for cutting heroin. An antihistamine.

METOPON: opiate stronger than morphine and with fewer side effects.

MICKY FINN: knockout drops of alcohol and chloral hydrate.

MICKEY MOUSE: petty, chicken, phony. Small drug habit. Policeman.

MICROGRAM: a unit of dosage of some drugs as LSD, 1/1,000,000th of a gram or 1/1,000th of a milligram. MCG, MIKE.

MILLIGRAM: 1/1,000th of a gram. MG.

M.M.D.A.: synthetic amphetamine.

MOD SQUAD: biracial couple or group.

MONOAMINE OXIDASE: (M.A.O.) INHIBITORS: nervous system stimulants related to amphetamines and used as mood elevators (i.e., Nardil, Marplan, Niamil, Parnate, Eutonyl, etc.). Potent and unpredictable, so dangerous. Potentiates action of alcohol, amphetamines, narcotics, sedatives, depressants, antihistamines, anesthetics and insulin. Deaths have resulted from its use with such drugs. Some get high and hallucinate on MAO and it is a very toxic drug (sometimes lethal).

MOOCH: to beg or leach.

MORNING GLORY: seeds of blue and white species as Wedding Bells, Heavenly Blue, Flying Saucers, Pearly Gates, etc. contain a chemical related to LSD and so have hallucinogenic properties. Aztecs used such seeds and called them OLOLIUQUI or TLITLITZEN. Stronger than grass but weaker than acid. ELSIE'S FRAPPE: milk, ice cream and seeds.

MORPHINE: one of the original opiates producing addiction. Now replaced by heroin. WHITE STUFF, HARD STUFF, MORPHO, M, MORPHIE, DREAMER, M.S., MORPH.

MOTHER'S DAY: day welfare check arrives. DAY THE EAGLE SCREAMS.

MOXIE: a loud mouth, wise guy, objectionable person. Also refers to having guts.

MUSHROOMS, SACRED: see PSILOCYBIN.

NALLINE: narcotic antagonist for treating an overdose of heroin.

NATCH TRIP: high produced by natural substances as mace, nutmeg, morning glory, peyote, mushrooms, grass, etc. See LEGAL HIGH.

NATIVE AMERICAN CHURCH: religious and healing rituals of some American Indian tribes in the west in which peyote is legally employed (i.e., Commanches, Kiowas, Omahas, Mescalero, Apaches, etc.

NEEDLE-FREAK: a very needle happy person. SPIKE FREAK.

NEEDLE-HAPPY: not genuine confirmed addict. Intermittent craving for injections with needle but only a weekend user. Fascinated with paraphernalia and mystique of mainlining cult but not truly addicted. SPIKE-HAPPY.

NEO-AMERICAN CHURCH: "religion" pushed by Leary in the mid-1960's with drugs as sacraments.

NITTY-GRITTY: truth, basic or fundamental facts. Reality underlying what appears on surface.

NIRVANA: oblivion, paradise, final freeing of soul from all that enslaves it, supreme happiness with all hatred and delusions eliminated.

NOLUDAR: a piperidine. Non-barbituric sedative. ROCHE.

NON-USER OF DRUGS: SQUARE, JOHN, BROWN SHOES, DO-RIGHTER, APPLE.

NO SWEAT: no worry, no bother.

NO WAY: absolute refusal to do something.

NOWHERE: situation or person that is boring, meaningless or lacks status.

NURD: one lacking any social graces or savvy. JERK.

NUTMEG: dried seeds of East Indian evergreen tree used as spice. Can produce euphoria and high said to be similar to that from pot. Used by inmates of prisons and sailors. Active ingredient is MYRISTICIN (ELEMICIN).

OFF THE WALL: unusual, surprising.

OLD LADY: common-law wife in communal living. Involved male is OLD MAN.

ON THE ROAD: travelling around leading nomadic life. ON THE RUN.

OPIUM: dried juice from the opium poppy and the basic ingredient from which morphine and heroin are processed. Smoked by the Chinese for years and brought to this country in the 19th Century. Formerly used in many patent medicines. Recently plain opium has become popular with some students for smoking. A true narcotic or opiate. Made into a ball, placed on screen or mesh in bottom of pipe and smoked. Also called POPPY, BLACK STUFF, TAR, PEN YEN, BROWN STUFF.

(continued on next page).

COOKING: heating opium to form it into a ball for smoking or heating with water to shoot. (COOK UP A PILL).
BLACK PILL: opium pellet in pipe.
TOXY: small container of opium. YEN HOCK: opium pipe.
YEN-SEE: opium ash. YEN-SEE SUEY: opium wine.
O.J. or OPIUM JOINT: opium added to marihuana. Cigarette.
BROWN HASH: alleged to be a form of opium.
GONG: opium pipe. GONG BEATER: opium smoker.
CHASING THE DRAGON: method of inhaling opium fumes through paper tube (QUILL).
PING PONG BALLS: small balls of opium for smoking.
LAY DOWN: place where opium is smoked.
ICE CREAM: opium.

OREGANO: herb resembling marihuana and used to cut pot. Inactive--an inert filler or stretcher.

ORIGINALS: clothing that has never been washed.

OUT FRONT: open, frank.

OUT OF IT: not part of drug scene; not in contact with things; not aware. OUT TO LUNCH.

OUT OF SIGHT: superb; too good to be believed; cannot be described by words. GROOVY: TOO MUCH.

OUT OF THE BODY: tripping and feeling outside one's own body. OUTSIDE MYSELF: OUT OF THIS WORLD.

OUT OF YOUR TREE: irrational, crazy.

OWSLEY: Originally acid made by underground chemist August Stanley Owsley III and said to be pure and potent.

PAD: room, apartment or house (not necessarily associated with drugs).

PARAHEXYL: semisynthetic extract of cannabis plant prepared from oil or resin. More potent than street pot. Use in experimental work on marihuana in the 1930's and 1940's. PYRAHEXYL, SYNHEXYL.

PAREGORIC: liquid opiate sometimes used as a temporary replacement for junk during a panic. P.G., P.O. See BLUE VELVET. User: GEE-HEAD.

PARTNER:	buddy; close friend.
PASS:	collapse, pass out; transfer of drugs; receive immunity from police.
P.C.P.:	see SERNYL.
PEACE:	word of universal salutation when meeting or leaving.
PEANUT BUTTER:	Mainlined with mayonnaise. It is unknown at present whether there are any psychological effects. Several cases have shown serious and extensive hemorrhages in various organs which were fatal.
PEPPER:	rotten green pepper said to be hallucinogenic. Apparently another hoax or put-on, like the banana bit. JACKSON ILLUSION PEPPER.
PERCODAN:	synthetic opiate recently being abused. OXYCODONE.
PEYOTE:	dwarf cactus which is hallucinogenic when eaten. Used by Western Indians in the Native American Church. Weaker than LSD and stronger than pot. Active ingredient is mescaline. TOP, CACTUS, BUTTON, ORGANIC or NATURAL MESCALINE. FULL MOON -- slice of peyote cactus. Also see MESCALINE.
PICK UP ON:	grasp; gain understanding of.
PIECE:	pistol, revolver, unit of measurement of a drug.
PIMP:	man who solicits for prostitute. STABLE: group of girls who work for a pimp.
PIN:	identify a specific detail or characteristic about a person. PINPOINT.
PINNED:	constricted pupils due to opiates (exception is demerol).
PIPERIDINE:	piperidyl benzilates are psychotomimetic drugs. Effects resemble atropine and also cause hallucinations, euphoria and delerium. Called "J.B." compounds. See DITRAN, LBJ, BENACTAZINE.
PLACIDYL:	non-barbiturate sedative.
PLANT YOUR SEED:	spread your philosophy through love, talk, sharing, etc.
PLASTIC:	part-time, flexible, phony, insecure, unreal.

PLASTIC HIPPIE: phony or pseduo-hippie who makes the scene weekends but is not serious drug user or really sympathetic with hippie philosophy.

POLICE AND ENFORCEMENT TERMS:

FUZZ: police. THE MAN, NARC, BULL, SAM, WHISKERS, UNCLE, FEDS, BULLS, SNOOPS, BIMS, G, BUSTER, T-MAN. HARNESS BULLS: uniformed officers. PIG and BLUE FACIST: derogatory terms.

BLACK AND WHITE: police car. SHORT: car (WHEELS, CAN). CRACK SHORT: steal a car.

RIP OFF: to rob or steal. BOOST, BEAT, TAKE OFF, BURN, STING, COP.

FINGER: to inform. BURN, DO IN, DROP A DIME, SNITCH, RAT, SPILL.

FINK: informer. STOOL PIGEON, STOOLY, PIGEON.

BURNED: recognition of identity of undercover agent. MADE.

FAKE A BLAST: undercover agent pretending to smoke a joint and get high.

DEADWOOD: undercover agent posing as drug user.

BUSTED: arrested. COLLARED, DROPPED, NICKED, BEEN HAD, BATTED OUT, HIT, GRABBED, CLIPPED, NAILED.

POPPED: picked up by police.

TOSS: to search. FRISK, SHAKE DOWN, RUMBLE.

FEDERAL BEEF: federal offense. JUG: to stab. HEIST: robbery.

SNUFF: to kill, eliminate.

HOT: wanted by police, stolen goods. RUN IT: transport stolen merchandise to fence.

THROW ROCKS: commit crime to support habit.

PAPER HANGING: supporting habit by forging checks.

JITTERBUGGING: gang fighting. RUMBLE: street fighting gangs.

VIOLATED: arrested for parole violation.

FLAT TIME: sentence without chance for parole.

BUM RAP: arrest or conviction when not guilty.

HACK: prison guard.

MASTER KEY: sledge hammer for breaking down door in raid.

BULL HORROR: the drug user's occupational disease, i.e., paranoia about being observed or busted. FUZZ FEAR.

CARRYING: possessing drugs on one's person when apprehended. DIRTY, HOLDING, HEELED.

CLEAN: not possessing drugs when apprehended. SWEET.

PLANT: to frame someone by surreptitously placing drugs on his person or in his pad to be used later as evidence. FRAME, SET UP.

(Continued on next page).

COOLER: jail, JOINT, LOCK UP, CAN, IRON HOUSE.
ON ICE: in jail. BOXED, SLAMMED, IN THE HOLE. ON THE SHELF, LOCKED UP.
ON THE STREET: out of jail. SWEET, FRESH, FRESH AND SWEET, ON THE BRICKS.
DUKE IN: to expose an undercover agent.
FENCE: buyer of hot or stolen goods.

POLITICO: political activist, usually of the New Left.

POW WOW: meeting of kindred spirits.

PRESCRIPTION: PAPER READER, SCRIPT, PER.

PROBES: deep discussions in confrontation therapy as in Daytop Village.

PSILOCIN: substance psilocybin is changed into psilocin in body during metabolism.

PSILOCYBIN: hallucinogen from the magic or sacred mushroom of Mexico. Used by Indians of Mexico for centuries. Stronger than pot but weaker than LSD. GOD'S FLESH, TEONANACTL, SIMPLE SIMON.

PSYCHEDELIC: mind manifesting, mind expanding, conscious expanding, mind altering or reality distorting. Applied to hallucinogenic drugs as acid, peyote, psilocybin, etc.

PSYCHEDELIC DELICATESSEN: shop specializing in equipment for psychedelic drug sessions.

PSYCH OUT: figure out. To disturb or disrupt.

PSYCHED OUT: irrational.

PSYCHED UP: emotionally excited.

PUT DOWN: criticize; discourage; knock something; deny. CUT UP. SHOOT DOWN.

PUT (LAY) ONE'S TRIP ON: attempt to persuade another that he should believe what you believe and think since that is more important than what he happens to believe and think. Force your influence on somebody.

PUTTING ME ON: fooling me; deliberately deceiving me.

PUT ON: a hoax. To fool or deceive.

QUILL: folded matchbox cover for snorting junk, speed or coke.

RACKED-UP:	upset, distraught, bothered. UNGLUED, UNHINGED, FLAPPABLE.
RAM-ROD:	forman in Daytop, etc., who supervises a work detail.
RAP:	communicate quietly and peacefully, discuss important matters, gossip, converse. RAPPING, CORTEX TAPPING, RIFFING, RASP.
READ:	to understand, to dig (i.e., "I read you.").
RE-ENTRY:	to return or come down from a trip (COME DOWN). To rejoin normal society after tour in treatment center.
RESIDENTIAL THERAPEUTIC COMMUNITY:	facility run by ex-addicts to treat drug dependent individuals by group encounter therapy. Takes 12-18 months of residence and is voluntary. Examples: Synanon, Daytop Village, Argosy House, etc.
RIGHT:	word used at end of phrase or sentence to check listener's attention. Implies an unasked question, i.e ., "Are you listening?" "Do you dig me?"
RIGHT ON:	in agreement or correct so continue on.
RITALIN:	mild stimulant and anti-depressant which elevates the mood and overcomes fatigue. Use in some individuals may lead to psychotic behavior and psychic dependence (habituation). Used by some to turn on. Bigger on West Coast than in the East.
SALAD:	see COMBINATIONS.
SAN FRANCISCO:	alleged psychedelic capital of the world. TRIPSVILLE, PSYCHEDELPHIA.
SATORI:	enlightenment; awakening to one's true inner self.
SCENE:	place where the action is; where something is happening; where it is at -- may be good or bad scene. Social pattern of drug use in a certain area.
SCREWED:	been had, taken advantage of.
SCREW UP:	to make mistakes. GOOF UP.
SCREWED UP:	mixed up, confused, neurotic.

SEDATIVES:	see BARBITURATES. Also included are non-barbiturates as DORIDEN, PLACIDYL and GUAALUDE. Both groups are physically addicting.
SERNYL:	animal tranquilizer (phencyclidine). Potent and dangerous hallucinogen. Used as a vehicle for acid sometimes and also marketed as T.H.C. P.C.P., HOG, K2, PEACE PILL, CYCLONES.
SET:	mental state of person about to take a drug plus his underlying psychological tendencies. Combination of 2 downers and 1 upper.
SETTING:	total environment in which user undergoes his drug experience; surroundings.
SET-UP:	to frame or plant evidence for a bust; combination of speed and goofballs.
SEX JUICE:	a put-on (oil of peppermint) and not an aphrodisiac. "68".
SHACK UP:	live with opposite sex without being married.
SHADES:	sun glasses. TEASHADES, SPECS.
SHAFT:	to take advantage of. SHAFTED: GIVE THE SHAFT.
SHIM:	one who from casual observation of hair, clothing, etc. could be either male or female (contraction of the words she and him). UNISEX, THE THIRD SEX.
SHINE:	reject.
SHOOK UP:	apprehensive, nervous, worried.
SHORT:	to cheat; a car.
SHUCK:	to deceive, lie or swindle. CON.
SHUCKS OFF:	fails to do assigned work effectively as in Daytop, Synanon, etc.
SILK:	white person.
SKIN HEAD:	young working-class Englishmen who shave their heads to show contempt for long-hairs (hippies) but who may use drugs themselves.
SLEIGH RIDE:	to take cocaine.

SMASH:	oil of cannabis with hashish for smoking.
SMOKE:	wood alcohol.
SNAG:	to catch.
SNOW JOB:	insincere conversation and flattery in attempting to persuade someone.
SOCK IT TO ME:	tell all the facts, speak plainly and honestly without reservation.
SPADE:	a Negro. BLACK, BLOOD.
SPACED-OUT:	in a daze or state of altered consciousness, usually from drug but not always. SPACED.
SPEED:	types of amphetamine as DESOXYN, METHEDRINE, METHAMPHETAMINE. Popped, snorted, or mainlined. SPOON: unit of measurement in which speed is packaged for sale. (From 1/4 to 1 teaspoon). CRYSTAL SHIP: syringe of speed. DIME: square or rectangular piece of aluminum foil containing $10 worth of speed. Synonyms for speed: CRYSTALS, CHALK, CRANK, DICE, CRINK, CHRIS, CHRISTINE, CRISTINA, DYNAMITE STOCKS, GREENIES, PEPPERMING STICK, CHRISTMAS TREES, STRAWBERRY SHORTCAKE, BLACK BEAUTIES.
SPEEDBALL:	combination of heroin with either amphetamine or cocaine for mainlining. HOT AND COLD, H AND C.
SPEED FREAK:	chronic user of speed. METH MONSTER, HYPER, SPEEDER. Groups of speed freaks hanging together known in some areas as CRANK COMMANDOS, METHEDRINE MARAUDERS, after famous World War II guerilla groups or special forces.
SPEEDING:	under effects of speed. BEHIND SPEED, CRANKING.
SPLIT:	to leave. CUT OUT, SLIDE.
SPOON:	measure of drug to be injected.
SPRING:	treat a person to a take or a joint. Free somebody from jail.
SQUARE:	not with it; anti-hip; conforming and conventional; tobacco cigarette. One who does not use drugs. BROWN SHOES, LAMES, STRAIGHT.
SQUARE JOINT:	tobacco cigarette.

SQUIRREL: addict who stashes large supply of drugs in a cache.

STIMULANTS: includes AMPHETAMINES, RITALIN, WYAMINE, T.M.A., T.M.M., M.D.A., M.M.D.A., D.O.E., D.O.E.T., D.M.A., D.M.D.A., EPHEDRINE, HUNGEX, PRELUDIN, TENUATE, RHINALGIN, PRIMATENE, TEPANIL, etc.

STONY: showing some features seen with drug users.

STRANGE: odd, weird, unique.

STRIP: area of street, sidewalk or grass on which hippies congregate (after Sunset Strip in Los Angeles). BEACH.

S.T.P.: dimethoxymethylamphetamine. "Serenity-Tranquility-Peace". Very potent and long-acting hallucinogen. Stronger and more dangerous than LSD. A megahallucinogen. Said to have been synthesized first by Dow Chemical Co. Rumored to be a secret nerve gas (it is not). Said to be named after the powerful motor additive "scientifically treated petroleum", hence S.T.P. Also called D.O.M., 72-HOUR BUMMER and D.O.A. (dead on arrival).

SUPER: groovy, great, fantastic.

SWEETIES: British term for Preludin, an amphetamine-like appetite suppressant, used like speed.

SWIFT: good, great.

SWING: actively participate in various activities such as drug subculture. To be free and uninhibited in general.

SWINGER: cat or chick who really swings.

SWISH: effeminate looking and acting fag.

SYNTHETIC OPIATES: ALPHAPRODINE, LERITINE, PRIWADOL, LEVODROMORAN, METOPON, NUMORPHAN, DEMEROL, PERCODAN, HYDROCODONE. Only last four are abused at present.

TAKE THE PIPE: commit suicide, kill one's self by overdose of drug.

TALL: good.

TALK DOWN: to bring a person down from a bum trip by rest, reassurance, sympathy, and support through rapping rather than by drug therapy.

TAR BEACH: rooftop used for sleeping or shooting.

TASTE OF HONEY:	pleasurable experience (may or may not be through drugs).
TENNYBOPPER:	pre-teenagers and early teenagers living at home who like to make the scene weekends and mingle with the college students. May or may not use drugs. LITTLE PEOPLE, BUBBLE GUMMERS, PIGTAILERS, and BAD NEWS.
TELL IT LIKE IT IS:	tell entire truth without embellishment or withholding; be strictly factual.
T.H.C.:	see MARIHUANA. TETRAHYDROCANNABINOL, SYNTHETIC GRASS.
THING:	one's chief interest or preoccupation . DO YOUR THING: do what intersts you or is best for you regardless of the consequences.
THIRD EYE:	the inward-looking eye; the new vision into oneself said to be provided by psychedelic drugs.
THREADS:	clothes. TWEEDS, VINES.
TICKED OFF:	angry. TEED OFF.
T.M.A.:	synthetic amphetamine.
TOGETHER:	In control of the situation; state of having a clean head after retraining from drug use. Opposite of APART.
TOUGH:	sharp; admirable; good.
TRANQUILIZERS:	commonly abused ones are Librium, Miltown, Valium, Valmid. DOWNERS, DOWNS, BACKWARDS, TRANKS, TRANQS. These are minor tranquilizers and produce physical addiction, unlike the major tranquilizers such as Thorazine, Stellazine, etc.
TRAVEL-AGENT:	dealer in hallucinogenic drugs such as LSD, etc.
TRICK:	client of prostitute. TURN A TRICK: solicit a customer.
TRIP:	experience that goes beyond ordinary thoughts, feelings and perceptions. Commonly produced by drugs but may occur without recourse to drugs. Classified as body or head type depending on whether manifestations are primarily physical (i.e., heroin) or mental (i.e., acid). Verb: to take drug and get high.

TRIP OUT:	to get high on drugs.
TRIPPING-OUT:	to go out of one's normal state of mind or to go on a trip. Ordinarily due to drugs, but may rarely be unrelated to drugs.
TRIPPER:	one who takes drugs to get high.
TUNE-IN:	to become aware and perceptive of things around one. Customarily drug activated but does not have to be.
TUNE-OUT:	ignore what is going on around one.
TURN-ABOUT:	a change of mind . TURNAROUND.
TURN-OFF:	to dispel interest in something, to bore or to produce indifference by some action.
TURN-ON:	to come alive, to become excited or affected by something or to become involved. Done with or without drugs.
TURN ON TO:	begin to show interest in something or somebody.
TURNED OFF:	disinterested.
TURNED ON:	under influence of drug.
TURP:	cough syrup with high codeine content. Name originated from turpine hydrate with codeine.
UNCOOL:	lack of self-control, inability to cope, unaware or ignorant.
UNDERGROUND:	subculture of youth with its ritual, mystique, costume, jargon, etc. Usually alienated and against society and the establishment. May or may not be drug oriented.
UNFLAPPABLE:	calm, unexcitable, imperturbable.
UNGLUED:	fallen apart emotionally, being uncool, not remaining unflappable in face of pressure (heat). UNHINGED, RACKED-UP, FLAPPABLE.
UP:	euphoric, elated or high (with or without drugs).
UP TIGHT:	nervous, anxious, worried or rigid.
USERS:	addicts and students from various high schools, colleges and universities.

VIBES:	(VIBS). perceptions, sensations, thought waves, atmosphere or spirit of a scene or happening. May be either good or bad vibes. VIBRATIONS.
VICE SQUAD:	ones in group who are clean of drugs.
VOYAGEUR:	person on hallucinogenic drug trip.
WAG TAIL:	to conform.
WAY OUT:	indescribable (good or bad). FAR OUT, FREAKY, KINKY.
WHERE IT'S AT:	real or imagined place where action or event is taking place.
WHITE LIGHT:	sudden complete comprehension of an idea or an ideology. Ultimate emotional experience behind a drug, especially acid or mescaline. Final discovery of one's inner self. Hallucination of blinding white light with a feeling of omniscience such as is said to occur sometimes from hallucinogenic drugs.
WIG:	the mind.
WIGGED OUT:	very excited, not in control emotionally. FLIPPED OUT.
WIG-OUT:	blow one's mind, become psychotic. Usually due to drugs but may be other precipitating factors.
WILD GERONIMO:	barbiturate in beer.
WOW:	exclamation of amazement, surprise, admiration, excitement, etc.
WYAMINE:	nasal inhaler containing stimulant related to amphetamine. SNIFFERS.
YIPPIE:	different from traditional hippie in that he is more vocal and more of an activist politically and otherwise.
YOU KNOW:	expression repeated frequently during talk but without any real meaning.
ZAP:	to overwhelm, i.e., zap the fuzz with love. To strike back peacefully, i.e., zap the man with flower power. ZAPPED: destroyed, caught.
Z.N.A.:	mixture of dill and monosodium glutinate smoked for alleged hallucinogenic effects. A put-on??
ZOO:	psychiatric hospital. FUNNY FARM, GIGGLE HOUSE. LOONY BIN.
ZOOM:	sernyl (PCP) on grass. ANGEL DUST, SUPER GRASS. Meaning of such street names varies with geographical location.

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DRUG ABUSE
PROBLEMS OF IDENTIFICATION

United States Department of Justice
Bureau of Narcotics and Dangerous Drugs*

It is important to recognize the symptoms and signs of drug abuse. The following outline was prepared by the Bureau of Narcotics and Dangerous Drugs based on the publication, Drug Abuse: Escape to Nowhere.

I. Common Symptons of Drug Abuse

A. Changes in school attendance, discipline and grades.
B. Unusual flare-ups or outbreaks of temper.
C. Poor physical appearance (often becomes slovenly).
D. Furtive behavior regarding drugs (especially when in possession).
E. Wearing of sunglasses at inappropriate times to hide dilated or constricted pupils.
F. Long-sleeved shirts worn constantly to hide needle marks (if injecting drugs).
G. Association with known drug abusers.
H. Borrowing money from students to purchase drugs.
I. Stealing small items from school or home.
J. Finding the student in odd places during the day such as closets, storage rooms, etc., to take drugs.
K. May attempt to appear inconspicuous in manner and appearance to mask drug usage.
L. Withdrawal from responsibility.
M. General change in overall attitude.

II. Manifestations of Specific Drugs

A. The Glue Sniffer

1. Odor of substance inhaled on breath and clothes.
2. Excess nasal secretions, watering of the eyes.
3. Poor muscular control, drowsiness or unconsciousness.
4. Presence of plastic or paper bags or rags containing dry plastic cement.
5. Usually becomes group oriented.

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* Government Printing Office 889-946 publication.

B. The Depressant Abuser (barbiturates - "Goofballs" - "Downs")

1. Symptoms of alcohol intoxication with one important exception no odor of alcohol on the breath.
2. Staggering or stumbling in classroom or home.
3. May fall asleep in class or at home.
4. Lacks interest in school and family activities.
5. Is drowsy and may appear disoriented.

C. The Stimulant Abuser (Amphetamine-"Bennies"-Speed)

1. Cause excess activity--user is irritable, argumentative, nervous, and has difficulty sitting still in classrooms.
2. Pupils are dilated.
3. Mouth and nose are dry with bad breath, causing user to lick his lip frequently and rub and scratch his nose.
4. Chain smoking.
5. Goes long periods without eating or sleeping.

D. The Narcotic Abuser (heroin, demerol, morphine)

1. Inhaling heroin in powder form leaves traces of white powder around the nostrils, causing redness and rawness.
2. Injecting heroin leaves scars on the inner surface of the arms and elbows (mainlining). This causes the student to wear long-sleeved shirts most of the time. User may inject drugs in body where needle marks will not readily be seen.
3. Users often leave syringes, bent spoons, bottle caps, eye-droppers, cotton and needles in lockers and rooms - this is a telltale sign of an addict.
4. In the classroom the pupil is lethargic, drowsy. His pupils are constricted and fail to respond to light.

E. The Marihuana Abuser

(These individuals are difficult to recognize unless they are under the influence of the drug at the time they are being observed.)

1. In the early stages student may appear animated and hysterical with rapid, loud talking and burst of laughter.
2. In the later stages the student is sleepy or stuporous.
3. Depth perception is distorted, making driving dangerous.
4. Unable to define reality from unreality e.g., will accept only their own point of view.
5. Affect on user varies from time to time, e.g., user may be docile most of the time but may become violent at other times.
6. Usually used in a group.

NOTE: Marihuana cigarettes are rolled in a double-thickness of brown or off-white cigarette paper. These cigarettes are smaller than a regular cigarette with the paper twisted or tucked in at both ends with tobacco that is greener in color than regular tobacco. The odor of burning marihuana resembles that of burning weeds or rope. Cigarettes are referred to as reefers, sticks, texas tea, pot, rope, Mary Jane, loco weed, jive, grass, hemp, hay. Many times is smoked in pipe (long stem, small bowl).

F. The Hallucinogen Abuser

(It is unlikely that students who use LSD will do so in a school-setting since these drugs are usually used in a group situation under special conditions.)

1. Users sit or recline quietly in a dream or trance-like state.

2. Users may become fearful and experience a degree of terror which makes them attempt to escape from the group.
3. The drug affects the mind primarily as opposed to physical functions, producing changes in mood and behavior.
4. Perceptual changes involve senses of sight, hearing, touch, body-image and time.

NOTE: The drug is odorless, tasteless, and colorless and may be found in the form of impregnated sugar cubes, cookies, or crackers. LSD is usually taken orally, but may be injected. It is imported in ampules of clear blue liquid.

DRUGS AND NEW RELIGIOUS CULTS

C. Douglas Gunn*

Religious forms that are strange to most Americans are now emerging from the youth culture. Basic to most of these is a renewed interest in mysticism, in man's experience of transcendence, in the possibility of experiencing "extraordinary reality." American interest in mysticism and exotic forms of religion is not new -- one can find, for example, such an interest in the Transcendentalism of Ralph Waldo Emerson -- and an American concern with vital, experiential religion reaching back at least to the Great Awakening of the 1720's. Yet in modern times, the emergence of religious cults of experience seems novel to many. There *is* novelty today -- in the unique role played by psychedelic drugs in shaping the form of these new religious cults.

In the 1950's, the "Beat Generation" discovered Zen Buddhism, which became their adopted (and adapted) form of mysticism. However, there were more people who merely talked about Zen experience than who actually had it, since there were few qualified Zen masters in this country from whom to learn. Book-taught Zen mysticism was dubious mysticism and even more dubious Zen.

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With the advent of psychedelic drugs, especially LSD, extraordinary experiences became easily available to all. It is hard to overemphasize the importance of this availability on subsequent development of our culture. To many psychedelic users familiar with oriental religious terminology, it seemed that these new drugs offered mystical experience, enlightenment, satori, without the rigors of prolonged (and painful) meditation or asceticism. To some users, the new pills were a kind of Western yoga, a means by which years of religious questing could be condensed into hours.

Now, it is clear that many -- probably most -- people who take psychedelic drugs do not do so primarily for religious motives. They do it for "kicks." Nevertheless, it would seem that a large number of users move back and forth between the two poles of "casual usage" and "religious usage." It is difficult if not impossible to clearly distinguish between sacred or profane usage of psychedelics. Some users who allege religious motives for drug-taking also enjoy casual tripping, while other users who initially approached the drugs for "kicks" alone later interpret their experiences in religious categories. With the present embargo on legal psychedelics, no one can say for certain how many people now associate these drugs with experiences they interpret as religious in nature.

The question of whether psychedelic experiences are "truly" religious or "authentically" mystic seems largely one of definition. This writer would wish to avoid the qualitative issue of the nature of these experiences: the data are insufficient and our tools neither well enough developed for interpreting it nor for giving us much assurance that we can claim validity in saying whether or not drug-induced experiences are mystical.

The real importance of psychedelic drugs for the growth of new religious cults in America lies less in the numbers who actually make a religion out of drug-taking than in the fact that the psychedelic experience has given to at least one generation their terminology to describe and evaluate experiences which they consider religious. In other words, the psychedelic experience and the language used to describe it have rapidly become normative in discussing not only drugs but in discussing other religious traditions and experiences as well. For example, the "high" of a chanter of the Hare Krishna mantra may be discussed and compared with that produced by pot; one may hear a "Jesus Freak" talking about "getting a better high with Jesus" than he did formerly with LSD; one may be "turned on" by various forms of meditation, and so on.

Thus the primary importance of the psychedelic experience for new religious cults in America is not that drug-taking underlies all of them. Far from it. Many of the most popular and growing cults, such as Transcendental Meditation and the Krishna Consciousness movement, disavow the use of drugs. Rather the importance of psychedelic drugs for such cults lies in the fact that the drugs provide a language framework in which religions are developing an articulated belief or theology. It is in the terms of psychedelic experience that religions -- old or new -- are being judged by America's youth culture.

Hence, discussion of religion in terms of the psychedelic turn-on in these days need not imply an actual drug experience on the part of the speaker. By this time, the psychedelic experience has been so widely publicized that nearly all college or high-school-age youth are familiar not only with its terminology but also with its reported effects and sensations -- whether or not they have actually experienced them. The centrality of the psychedelic experience as the most powerful spiritual experience affecting their generation provides the youth culture with more than a religious terminology. It means that they tend to judge other (non-drug) experiences, including the rituals and activities of the traditional religions of our society, in similar terms. Does church or synagogue, Easter or Seder, sacrament or sermon "turn on" anyone? Experience is central to religion among youth. Extraordinary experience is sought, and is judged in terms of the psychedelic categories.

Although the vocabulary of psychedelic drugs remains normative, other techniques of mysticism are becoming increasingly popular. Whether they will become a major religious force in America remains to be seen. Meditation, chanting and various forms of yoga allegedly provide "safe" and "natural" ways of achieving experiences analagous to the psychedelic. The suppression of drugs aids the growth of such cults, since cults are legal and the drugs are not. Concern with man's ineptitude in handling his own environment, as witnessed in such nutritional disasters as mercury-polluted fish, has led some seekers of the supra-normal to avoid man-made drugs (like LSD) in favor of "natural" techniques of transcendence such as meditation. On the other hand, some people, despairing of the future of the world as it rushes into ecological disaster, show little concern for their own systems and continue on drugs with little thought for the morrow. Paths to experience are many, and everyone decides for himself which, if any, he will take.

For the immediate future, however, it would seem that the ease with which the psychedelic drugs produce a state of extraordinary reality, and the fact that they have played such a large role in the formation of a culture differentiated from "establishment" society, makes it likely that they will continue to be the norm by which religion will be judged by the youth culture for some time to come.

Suggestions for further reading:

A. On mystical and exotic religions in America:

Hal Bridges. American Mysticism from William James to Zen.
New York: Harper and Row, 1970

J. Stillson Judah. The History and Philosophy of the Metaphysical Movements in America.
Philadelphia: Westminster Press, 1967

Charles S. Braden. These Also Believe: A Study of Modern American Cults and Minority Religious Movements.
New York: Macmillan, 1949

B. On drugs, religion and the youth culture:

*William Braden. The Private Sea: LSD and the Search for God.
Chicago: Quadrangle Books, 1967

*Timothy Leary. High Priest.
New York: World Publishing Co., 1968

*Timothy Leary. The Politics of Ecstasy.
New York: G. P. Putnam's Sons, 1968

*Walter Houston Clark. Chemical Ecstacy: Psychedelic Drugs and Religion.
New York: Sheed and Ward, 1969

*Lewis Yablonsky. The Hippie Trip.
New York: Western Publishing Co. 1968

*Jesse Kornbluth, ed. Notes from the New Underground.
New York: Viking Press, 1968

*Mitchell Goodman. The Movement Toward a New America.
New York: Alfred Knopf/Pilgrim Press, 1970

*Nicholas von Hoffman. We Are the People Our Parents Warned Us Against.
Chicago: Quadrangle Books, 1968

*Jerry Hopkins, ed. The Hippie Papers.
New York: New American Library (Signet paperback), 1968

*Tom Wolfe. The Electric Kool-Aid Acid Test.
New York: Farrar, Straus and Giroux, 1968

*Theodore Roszak. The Making of a Counter Culture.
Garden City: Doubleday, 1969

Jacob Needleman. The New Religions.
Garden City: Doubleday, 1970

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* denotes books available also in paper editions.

THE DRUG CHALLENGE

Michael V. Reagen*

The use and misuse of drugs is extensive in America. All indications suggest that in every age group in our society the extent of psychological and physiological dependence on drugs is so widespread that it is having a profound impact on our national life style.

Consider just five statistics:

1. A number of published estimates by credible sources indicate that at least twenty million Americans (almost ten per cent of our total population -- half of which is under the age of twenty-six) reportedly use marijuana on a routine basis.
2. The National Institute of Mental Health estimates that 200,000 Americans are addicted to hard drugs.
3. The U.S. pharmaceutical houses report through their national associations that they annually manufacture more than 350 tons of barbiturates -- an amount sufficient to put the entire population of the United States to sleep every night for three weeks.
4. The N.Y. Chamber of Commerce reported in a recent study on the incidence of drug abuse in business and industry in New York State that an estimated 500,000 Americans illegally use

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prescription drugs.

5. According to the New York State Narcotic Addiction Control Commission, more than 30,000 known heroin addicts with individual habits ranging in cost from $7,000 to $15,000 per year live in N.Y. State.

Statements on drug use and misuse abound in a bewildering array. Close scrutiny of these statements, however, yield three facts: First, data are admittedly incomplete and inaccurate (but more Americans than is normally suspected regularly use and misuse drugs in one form or another); second, the incidence of drug usage among the young is growing at an alarming rate; and third, the heart of the drug problem exists not in our schools but in our society.

It is important to realize that this last statement rests on the broad definition of drugs as substances which act on the central nervous system to produce unusual drowsiness, dullness, perceptional distortion, sleep, insensibility, pain reduction and/or euphoria.

Included under this definition are a number of familiar drugs: morphine, codeine, amphetamines, barbiturates, heroin, opium, hashish, cocaine, marijuana, and hallucinogens. Also included under this definition are a few we do not normally consider: volatiles, tobacco, coffee, tea and alcohol.

Social and behavioral scientists using this definition suggest more adults than youngsters regularly drug themselves; however, during the past decade the emphasis has been on drug use and abuse by children. Often, it is easier for adults to focus on the behavior of children than upon an examination of their own behavior.

Children, on the other hand, not only observe and evaluate their own behavior but also that of adults. They may imitate their peers but they also model their behavior on what "daddy says" and on what "daddy does." Adults lose credibility when they react to the fast pace of modern life by smoking, drinking and taking pills while at the same time criticizing comparable behavior in children. Children soon become aware of adult dependence on these drugs and not infrequently interpret criticism as hypocritical.

During the past ten years American adults have spent millions of dollars on highly-publicized programs designed to sell the negative aspects of drug abuse and addiction to children -- in the same way soap powder is sold to adults. If the objective of these programs has been to reduce the incidence of drug usage by children, then the programs have clearly not sold themselves. More youngsters drug themselves today than they did ten years ago. Why have programs failed? No one can be sure but research indicates seven significant flaws:

1. The programs do not "tell it like it is." They stress the negative aspects of drug abuse without mentioning the pleasurable aspects. They present information which the youngsters (either from personal experience or from shared experiences with peers) can easily deny. For example, programs often either state or imply that marijuana smoking automatically leads to using hard drugs. Even if it were true that every heroin addict smoked marijuana at one time in his life, it is not true that every marijuana smoker goes on to use physiologically addictive narcotics.

2. Programs have not addressed themselves to the differing viewpoints adults and youngsters have on the drug problem. While there is general agreement between both generations that hard drugs are harmful (especially with respect to the opiates), there is a wide divergence of opinion among both youngsters and adults about the possible harmful effects of soft drugs such as marijuana. Some youngsters see marijuana as a safe alternative to the use of alcohol, except for the possibility that they may be caught for illegally possessing and using it. Medical evidence only clouds the picture because at this writing the data are inconclusive as to whether or not recreational use of marijuana and some other soft drugs -- in their pure form -- is inherently damaging either psychologically or physiologically.

3. Programs reach children at too late an age. Physicians and police report an increase in narcotics use by elementary and junior high school students in our metropolitan area during the past two years.

   By the time youngsters reach high school they have already been exposed to a drug culture, if not through personal experience then surely through their observations of adult behavior and through the artifacts of their culture: music, films, magazines, and the mass media. Dr. William Alsever of Syracuse University's Student Health Service believes many students who use drugs in college brought their drug habits with them from home. He also suggests that the acknowledged drug problem in the Armed Forces may represent a similar phenomenon.

5. Youngsters are rarely involved in planning the programs. As a result, they usually "tune out" on drug prevention programs. They do not immediately perceive any relevance to their personal knowledge, experience or situations or see any compelling reason why they should force themselves to find any relevance.

6. The programs often fail to positively reinforce one another. This flaw is very evident in our metropolitan area. Here in Syracuse at least fifteen individuals or organizations offer narcotics education programs -- individually and collectively each provides a genuine public service that results in a minimal impact on the drug problem. Because of intense competition to gain recognition for their specific efforts to alleviate the drug problem, little cooperation and coordination has developed for an overall strategy which could maximize possibilities for making all programs successful in their impact.

7. Programs often use inappropriate techniques and strategies. One of the most inappropriate techniques or strategies for dealing with the drug problem in schools is for a school to deny any knowledge of drug use within its school population. It is most unlikely that the population of students in any one school is so unique a sample of the total population of

students in the United States that it has completely isolated itself from drug problems.

Some schools deal with the issue in a superficial manner, e.g., handing out pamphlets or providing an hour's lecture in health education classes. Still others lump "hard" and "soft" drugs together, use the shock technique of showing a "horror" film depicting the evil consequences of hard drug addiction or have a former addict speak about heroin.

These attempts, while influencing some impressionable youngsters, usually "turn off" the majority of students, who may be merely curious about marijuana. As a result, these techniques and strategies are skeptically viewed by youngsters as just more attempts by adults to control, falsify, intimidate and to otherwise deny youngsters free expression and the opportunity to "do their own thing." While these techniques and strategies are conceived with good intentions, good intentions do not necessarily lead to good results.

However, through the cooperation of interested citizens and federal, state and local government officials, efforts are now being made to correct the weaknesses of previous programs and to launch a coordinated attack on the drug problem in our metropolitan area.

The first step to this coordinated attack was in the spring of 1970 with the establishment of the Mayor's Temporary Commission on Narcotics Abuse Addiction in Syracuse. Through the invitation of Mayor Lee Alexander, twenty-one citizens representing various supportive services met throughout the summer of 1970 to study comprehensively the drug problem in the Syracuse metropolitan area.

The Commission proved to be a genuine working force. Shared with the Commission was information obtained from a fifty-seven item questionnaire completed by more than 15,000 students in grades 7 through 12 in both private and public schools in the City of Syracuse. The students reported that 12.7% of them had smoked marijuana; 3.5% of them had tried speed; 1.6% of them had tried heroin; 4.6% had tried acid or LSD; 8.3% had tried pep pills and 11.8% had sniffed glue or other volatile substances.

Throughout the summer of 1970 the Commission, chaired by the author, met with a variety of individuals knowledgeable about the drug problem in the Syracuse Metropolitan area. As a result of the Commission's hearings and investigations a report calling for a three-pronged attack to curb drug use and drug pushing in the Syracuse metropolitan area was begun on October 17, 1970.

The Temporary Commission's report called for: first, establishment of a comprehensive school drug education program to be conducted throughout Onondaga County; second, establishment of a City-County Drug Abuse Commission to coordinate all the efforts in the areas of education, law enforcement, treatment and rehabilitation to combat drug abuse in our community; and third, formation of a Central Narcotics Squad involving City-County police agencies to enforce laws that relate to drug abuse and drug pushing.

With the submission of its final report to the Mayor, the Temporary Commission no longer met. In its final comments, the Commission took note of the apathetic attitude of the general public toward the drug abuse problem. The Commission observed that there was in our metropolitan area an apparent lack of concern about drugs, not only by the general public but also by social and political institutions. Only occasional shortsighted, hysterical public utterances and reactions had broken an otherwise long seige of malaise.

The impact drugs are having on our young people and on our culture is phenomenal. Scientists working with our government in casting alternative futures for our society are alarmed. Some see millions of future Americans "turning on" with drugs as a normal recreational pasttime that will be legally and morally blessed by a society so affluent that only a few will work while a majority play. All, however, see the immediate personal horror for millions of individuals in the general societal discord unless our society as a whole addresses itself to the drug problem.

During the latter part of the summer of August, 1970, Syracuse University (through its continuing education arm -- University College), contracted with the New York State Education Department to develop and field a year-long drug program for six school districts in major cities in New York State outside of New York City to be under the direction of Professor Thomas Briggs of Syracuse University, School of Social Work. Target districts included Yonkers, Albany, Utica, Syracuse, Rochester, and Buffalo.

Each city was invited to select a number of teams consisting of a school administrator, a guidance counselor, a community leader and two students. These teams (a total of 85 persons) were involved in a week-long workshop at the University's Sagamore Conference Center and, then, were offered consultation for a period of two months.

There were four objectives behind the "Sagamore Experiment" as it has now come to be called:

1. To provide the participants in the experiment with basic, factual and up-to-date data concerning drug use and abuse.
2. To provide the participants with the opportunity to discuss and become involved with affective new techniques of dealing with drug education at the school level.
3. To enable each participating team to develop its own community action plan to attack the drug problem in its city.
4. To provide intensive leadership and planning training for student members of the teams.

The results of the Sagamore Experiment were mixed. In several cities, the teams were quite successful in implementing new and unique approached to the drug abuse problem and, at this writing, seem to be bearing fruit. In two cities the experiment achieved only modest results and in the remaining city, it was obviously a failure.

The key variable underscoring the success or failure of the Sagamore Experiment seemed to be the degree of interest and dedication of the participants. The Sagamore Experiment has, however, provided us with a useful model for launching a comprehensive preventive drug abuse education program in this metropolitan area.

Throughout 1970 and the spring of 1971, City and County officials studied the recommendations of the Mayor's Temporary Commission. In May, 1971, the City and County legislatures established the first City-County Drug Abuse Commission. The enabling legislation establishes the Commission and gives it five functions;

1. To act as a review board for drug abuse programs serving the City of Syracuse and Onondaga County.
2. To act as a coordinating agency for all drug abuse programs in Syracuse and Onondaga County.
3. To act as a clearing house for information about drug abuse programs and services available to the residences of Syracuse and Onondaga County.
4. To act as a sounding board for all future drug abuse programs in Syracuse and Onondaga County.
5. To act as a stimulus for new approaches in dealing with the drug dilemma in the City and County.

The City-County Drug Abuse Commission has broad recommendatory and investigatory powers and reports directly to the County Executive and the Mayor. It has four subcommittees -- one each on Treatment and Rehabilitation, Law Enforcement, Education , and Priorities.

At this writing the Commission is in the process of organizing itself, meeting with representatives of the various public and private agencies in the City and County and taking steps to provide itself with a staff to carry out the functions given to it by the County Legislature and the Syracuse Common Council.

During the winter of 1970-1971, superintendents of the twenty-one school districts in Onondaga County met regularly to discuss ways in which they might work more cooperatively to combat drug abuse among the children of the metropolitan area. A task force was formed under the leadership of Dr. Harold Ranken, Superintendent of Schools in the Jamesville-DeWitt school district. The task force, with the assistance of Dr. Donald Boudreau, Commissioner of Mental Hygiene for Onondaga County, applied for funds through the New York Narcotics Addiction Control Commission (NACC) to implement the recommendations on the comprehensive education program made by the Mayor's Temporary Commission.

The result of the Superintendent's task force was that NACC granted all the school districts of Onondaga County 1.8 million dollars. A small portion of that grant provided for the establishment of the Institute for Drug Education at Syracuse (IDEAS).

The Institute will train over 550 school personnel, formed into teams, representing every school building in Onondaga County. These teams are expected to return to their school and to conduct inservice training for other teachers, students and parents. They will also work with appropriate school officials in developing and coordinating preventive drug abuse education programs in the school curriculum for each district. The solution to any community problem demands the cooperation and interest of all the members of that community: The degree to which the community solves its problems is the degree to which each segment of that community cooperates in finding the solutions.

DRUG SURVEY IN SYRACUSE SCHOOLS

Mayor's Temporary Commission on Narcotics Abuse and Addiction

During 1970, the Mayor's Temporary Commission on Narcotics Abuse and Addiction in Syracuse conducted a survey in the City's junior and senior high schools to enlist the help of students in obtaining both their opinions and knowledge on the availability and use of drugs. "Drug use" was defined as the use of drugs for purposes other than those guided by a doctor's prescription. The questionnaire was returned by 15,140 students; however, not all of the questions on each questionnaire were completed by the students.

Anyone familiar with surveys will know the hazards of making generalizations based upon responses which are given to one question or set of questions, especially when all questions have not been answered and all questionnaires have not been returned. We have not attempted to give an interpretation or an in-depth analysis of the data included in the following questionnaire. In fact, the information contained in the questionnaire is probably out of date even for the 15,140 students who returned the questionnaire last year. Our purpose is to furnish raw data which may or may not prove useful to teams involved in IDEAS in evaluating some of their own impressions with regard to drug use in schools.

1-2 SCHOOL ______ RESULTS FOR TOTAL CITY
(1-2)

3-4 GRADE ______ TOTAL NUMBER 15,140
(3-4)

______ 07
______ 08
______ 09
______ 10
______ 11
______ 12

5. SEX
(5)

______ 1. Male
______ 2. Female

6. Have you ever smoked Marijuana (Pot)?
(6)

		TOTAL NUMBER	
87.3	1. No	13,221	
12.1	2. Yes	1,843	

7. Are you currently smoking Marijuana (Pot)?
(7)

		TOTAL NUMBER	
93.1	1. No.	14,100	
2.7	2. Yes, once or twice a month	418	
1.1	3. Yes, weekends only	179	
0.4	4. Yes, once a week	61	
1.4	5. Yes, more than once a week but not daily	221	
0.6	6. Daily	100	
6.5	TOTAL YES	979	15,079

8. Have you ever tried Speed?
(8)

		TOTAL NUMBER	
96.5	1. No.	14,617	
3.1	2. Yes	480	

. Are you currently using Speed?
(9)

		TOTAL NUMBER	
98.4	1. No.	14,902	
0.4	2. Yes, once or twice a month	75	
0.1	3. Yes, weekends only	27	
-	4. Yes, once a week	15	
0.1	5. Yes, more than once a week, but not daily	23	
0.2	6. Daily	38	
1.2	TOTAL YES	178	15,080

10. Have you ever tried Heroin?
(10)

		TOTAL NUMBER
98.4	1. No.	14,898
1.1	2. Yes	178

11. Are you currently using Heroin?
(11)

98.8	1. No.	14,972	
0.2	2. Yes, once or twice a month	35	
-	3. Yes, weekends only	10	
-	4. Yes, once a week	7	
-	5. Yes, more than once a week, but not daily	13	
0.1	6. Daily	28	
0.6	TOTAL	93	15,065

12. Have you ever tried Acid?
(12)

95.4	1. No.	14,449
4.0	2. Yes	613

13. Are you currently using Acid?
(13)

97.2	1. No.	14,730	
1.1	2. Yes, once or twice a month	169	
0.3	3. Yes, weekends only	50	
0.1	4. Yes, once a week	26	
0.1	5. Yes, more than once a week, but not daily	24	
0.2	6. Daily	33	
2.0	TOTAL YES	302	15,032

14. If you answered "yes" to the above, have you any flash backs?
(14)

65.7	1. No.	403
34.3	2. Yes	210
		613

15. Have you ever tried Pep Pills?
(15)

91.7	1. No.	13,894
7.2	2. Yes	1,103

16. Are you currently using Pep Pills?
(16)

97.0	1. No.	14,697	
1.0	2. Yes, once or twice a month	155	
0.2	3. Yes, weekends only	33	
0.1	4. Yes, once a week	26	
0.2	5. Yes, more than once a week, but not daily	45	
0.4	6. Daily	75	
2.2	TOTAL YES	334	15,031

17. Have you ever sniffed Glue or other volatile substances?
(volatile substances; gasoline, aerosol, paint thinner, etc.)
(17)

88.2	1. No	13,357
11.0	2. Yes	1,676

18. Are you currently sniffing Glue or other volatiles?
(18)

97.5	1. No.	14,766	
1.0	2. Yes, once or twice a month	162	
0.2	3. Yes, weekends only	34	
0.1	4. Yes, once a week	16	
0.2	5. Yes, more than once a week, but not daily	35	
0.2	6. Daily	43	
1.9	TOTAL YES	290	15,056

19. When did you first try drugs?
(19)

84.1	1. Never have	2,746
1.3	2. Before age 13	201
1.6	3. 13 years old	244
2.7	4. 14 years old	416
3.2	5. 15 years old	485
3.2	6. 16 years old	487
2.4	7. 17 years old	375
0.4	8. 18 years old	70
–	9. 19 years old and over	7

20. Why did you start using drugs?
(20)

84.3	1. Never have	12,772
0.8	2. To be part of "the group"	124
1.0	3. To expand the "mind"	154
1.7	4. To escape from "problems"	261
8.5	5. Curious about its effects	1,298
2.6	6. Other	407

21. Who started you using drugs?
(21)

84.2	1. Never have	12,751
4.7	2. Yourself	713
5.9	3. A friend	905
2.4	4. A group of friends	365
0.5	5. An older brother or sister	89
0.3	6. Parent	46
0.2	7. A stranger	41
0.7	8. Other	109

22. Where do you usually use drugs?
(22)

85.5	1. Never do	12, 952
1.2	2. At school	193
2.4	3. In my own home	364
3.7	4. At parties or social gatherings	562
1.0	5. In cars	166

Question 22 continued on next page

0.6	6. Parks	99
1.3	7. Friends' houses	210
1.7	8. All of the above 2-7	262
1.1	9. Other	167

23. With whom do you usually use drugs?
(23)

84.5	1. Never have	12,800
2.2	2. Alone	340
0.3	3. With younger students	58
7.3	4. With students my own age	1,119
0.5	5. With non students my own age	87
0.8	6. With college students	131
1.0	7. With older students not in college	162
0.2	8. With adults	43
1.3	9. Other	210

24. If you have not tried drugs is it because of
(24)

18.1	1. Legal reasons	2,754
24.8	2. Moral reasons	3,769
9.7	3. Fear of having a bad trip or bad experience	1,474
4.7	4. No opportunity	714
2.9	5. Parent disapproval	450
23.5	6. Other reasons	3,570

25. If you have tried drugs and no longer use them, is it because of
(25)

6.2	1. Legal reasons	943
3.7	2. Moral reasons	565
1.7	3. Knowing friends who have had bad experiences	262
1.0	4. Influence of a friend who is a non-user	166
0.9	5. Bad personal experience with drugs	147
0.7	6. Parent pressure	121
2.0	7. Education as to the use of drugs	305
8.5	8. Other reasons	1,296

26. Have you ever sold Marijuana (Pot)?
(26)

95.5	1. No	14,467
3.1	2. Yes	477

27. Have you ever sold Speed, Acid, or Pep Pills?
(27)

97.1	1. No	14,714
1.9	2. Yes	302

28. Have you ever sold Heroin?
(28)

98.3	1. No.	14,888
0.7	2. Yes	118

29. Have you ever purchased Marijuana (Pot) on school property?
(29)

95.4	1. No	14,446
3.8	2. Yes	580

30. Have you ever purchased Pep Pills on school property?
(30)

97.2	1. No	14,725
1.9	2. Yes	295

31. Have you ever purchased Acid on school property?
(31)

97.4	1. No	14,757
1.7	2. Yes	258

32. Have you ever purchased Speed on School property?
(32)

97.9	1. No	14,825
1.2	2. Yes	185

33. Have you ever accepted for free drugs on school property?
(33)

94.1	1. No	14,250
3.9	2. Yes	605

34. How difficult is it to purchase soft drugs?
(34)

14.7	1. They are not available to my knowledge	2,239
1.9	2. They are difficult to obtain	291
24.2	3. They are easy to obtain	3,665
55.3	4. I don't really know	8,380

35. How difficult is it to purchase hard drugs?
(35)

15.5	1. They are not available to my knowledge	2,359
6.6	2. They are difficult to obtain	1,002
10.0	3. They are easy to obtain	1,526
64.0	4. I don't really know	9,691

36. Should Marijuana be legalized?
(36)

71.9	1. No	10,895
24.4	2. Yes	3,701

37. If you had an opportunity to try drugs, would you try?

A. (38) Marijuana

88.6	1. No	11,715
7.3	2. Yes	2,225
2.7	3. Currently using	827

B. (39) Speed

93.7	1. No	14,191
3.4	2. Yes	528
1.1	3. Currently using	168

C. (40) Acid

94.1	1. No	14,249
2.9	2. Yes	448
1.2	3. Currently using	191

D. (41) Heroin

95.5	1. No	14,462
1.4	2. Yes	212
0.4	3. Currently using	70

42. If you were having a problem with drugs, who would you turn to first for help in your school?
(42)

22.6	1. Guidance Counselor	3,428
7.4	2. School Nurse-teacher	1,131
3.7	3. Physical Education Teacher	566
4.0	4. Principal or Assistance Principal	620
3.7	5. Science teacher	564
4.6	6. Health Education Teacher	711
22.2	7. Another Student	3,367
12.8	8. There is no one	1,943
12.9	9. Other	1,955

43. If you were having a problem with drugs, who would you turn to first for help outside of school?
(43)

28.2	1. Parents	4,278
5.5	2. Other adult	836
24.8	3. Friend	3,767
10.9	4. Clergyman (Minister, Priest, Rabbi)	1,661
1.1	5. Law Officer	173
3.5	6. Community Agency (DEN or 1012)	541
11.6	7. Doctor or Hospital	1,765
4.5	8. There is no one	692
4.2	9. Other	644

44. How well informed are you about drugs?
(44)

17.8	1. Not very well informed	2,708
26.7	2. Have some information	4,044
38.8	3. Fairly well informed	5,887
14.5	4. Very well informed	2,199

45. Do you think that the use of certain drugs has any effect on the unborn child?

(45)

6.0	1. No	913
76.3	2. Yes	11,556
15.9	3. Don't know	2,411

46. Would you recommend the use of drugs to a person who means a lot to you (friends, relatives, etc.)?
(46)

85.6	1. No	12,962
3.9	2. Yes	594
8.6	3. Don't know	1,313

47. In my opinion, I would be most willing to have information on drugs presented by (check one)
(47)

3.8	1. Priest, Minister, Rabbi	578
6.1	2. Police	931
56.7	3. Ex-Addict	8,585
3.9	4. Classroom teacher	594
3.6	5. Parent	556
13.8	6. Medical Authority	2,090
2.6	7. Pupil Services Personnel (Guidance Counselor, School Nurse-Teacher Psychologist)	396
2.2	8. Community Specialist	346
4.1	9. Other	634

48. Which of the following educational techniques would you recommend to give you information about drugs?
(48)

30.8	1. Small group with discussion leader	4,664
8.1	2. Large group (assemblies)	1,228
25.4	3. Films-filmstrips or other audiovisual materials	3,850
20.7	4. Independent conference with someone knowledgeable about drugs	3,141
4.8	5. Information resource center in school for independent study	740
6.4	6. Other	973

49. In which of the following groups would you classify your family income?
(49)

6.3	1. Up to $5,000 per year (less than $100 per week)	956
27.4	2. From $5,000 to $10,000 per year ($100 to $200 per week)	4,152
20.6	3. $10,000 to $15,000 per year ($200 to $300 per week)	3,125
9.9	4. Over $15,000 per year	1,513
32.7	5. I don't know my family income	4,952

50. Please check one of the following:

(50)

45.1	1. My father or male guardian works	6,830
9.3	2. My mother or female guardian works	1,412
37.6	3. Both parents or guardians work	5,697
4.1	4. Neither parents or guardians work	627

51. What is the highest level of education completed by your father or male guardian? (check one)

(51)

15.0	1. Junior High School	2,279
39.3	2. Senior High School or Equivalency	5,953
2.4	3. Less than 1 year college	370
4.3	4. 1 year college	665
3.8	5. Business school or college	584
1.7	6. Vocational training program	261
4.1	7. Junior college or other 2 year college	630
12.1	8. 4 year college	1,845
9.5	9. Education beyond 4 years college	1,439

52. What is the highest level of education completed by your mother or female guardian? (check one)

(52)

13.6	1. Junior High School	2,071
48.7	2. Senior High School	7,375
1.6	3. Less than 1 year college	252
3.2	4. 1 year college	489
7.2	5. Business school or college	1,092
1.6	6. Vocational training program	252
4.0	7. Junior college or other 2 year college	609
9.5	8. 4 year college	1,444
4.7	9. Education beyond 4 years college	714

53. Do you have a brother or sister who is now in college or has graduated from college?

(53)

65.7	1. No	9,961
31.6	2. Yes	4,791

54. Are you living with? (check one)

(54)

79.7	1. Mother & Father	12,081
12.9	2. Mother only	1,960
2.1	3. Father only	321
1.5	4. Male and Female guardian	238
0.1	5. Male guardian only	25
0.4	6. Female guardian only	70
0.1	7. Alone	30
0.2	8. With a friend or friends	43
0.6	9. Other	101

55. Which of the following represent your relationship with your father or male guardian?
(55)

34.7	1. I can talk to him anytime about my problems	5,266
37.4	2. I can talk to him some of the time	5,669
17.2	3. I can't talk to him at all about my problems	2,604
6.7	4. I have no father or male guardian	1,021

56. Which of the following represent your relationship with your mother or female guardian?
(56)

50.5	1. I can talk with her anytime about my problems	7,651
34.7	2. I can talk with her some of the time	5,265
9.9	3. I can't talk to her at all about my problems	1,513
1.4	4. I have no mother or female guardian	217

57. Do you consider yourself to be
(57)

68.3	1. An average student	10,351
23.7	2. An above average student	3,598
4.5	3. A below average student	688

Total N = 15,140

THE DRUG PROBLEM IN CENTRAL NEW YORK

Greg Glassner*

Drug Fear Grows -- 562 CNY arrests in 1970

In New York City, drug abuse has replaced the automobile as the number one killer of 18 to 25 year olds. Many specialists close to the drug scene in Central New York fear that the problem -- if unchecked -- will also reach crises proportions here.

They point to drugs as a relatively new social problem. Few arrests were made before 1965, rehabilitation facilities were virtually unknown here a year ago, and only recently have politicians taken up the issue.

Law enforcement officials point to an alarming spread of hard drugs into wealthy suburbs and rural areas, yet many parents and educators refuse to believe it.

Chief Investigator James R. McCaig of the State Police Narcotics Unit in Oneida, who covers a seven county area, flatly states "You can buy drugs in the corridors of any high school in the area."

Since McCaig's agents are responsible for Onondaga, Oswego, Madison, Oneida, Herkimer, Jefferson and Lewis Counties, his statements about the problem "bring it all back home."

Heroin - the killer - has long been associated as an inner city, or ghetto problem, but police and medical officials agree that the drug can be found "in DeWitt and Marcellus."

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*During June 1971 the HERALD JOURNAL ran a series of articles written by Greg Glassner, one of its reporters, on the drug problem in Central New York, its magnitude, misconceptions, and solutions. We have been given permission by the HERALD JOURNAL to reproduce this series for I.D.E.A.S.

Law enforcement officials express alarm over the youthful flirtation with drugs, drug culture, and "acid-rock" music because it represents a growing trend among a whole generation.

"I don't see this thing leveling off for another four or five years," McCaig said, adding that law enforcement alone cannot do the job effectively."

True Problem

McCaig admits that his comments about the size of the problem are greeted with a range of emotions from indignation to flat denials, but states adamantly, "I know it's true."

Drug Problem Growing

One educator who has studied the problem locally said that arrest statistics reflect only "top of the iceburg parameters" but increases in both arrests and case loads are dramatic and startling.

In Onondaga County alone, the State Police arrested 140 persons on narcotic offenses in 1968, 203 in 1969 and 226 in 1970. Total arrests in the seven county Central New York area were 562 in 1970.

Although the majority of the State Police arrests are for selling marijuana and hashish, McCaig pointed out that there were 12 arrests for amphetimines and barbiturates, twenty-six for LSD and other hallucinogens, and 37 for heroin in 1970.

Drug related arrests by the Syracuse Police Department show a trend similar to the State Police statistics. In 1964 there were 11 arrests, in 1965, 22; in 1966, 24; 32 in 1967; 128 in 1968; 115 in 1969 and 150 in 1970.

Lt. Charles Delaney of the Onondaga County Sheriff's Department said there really was no drug problem five years ago. Although the department averages about 70 to 75 arrests a year now, there were none prior to 1965.

Delaney, who also explains that his statements are greeted with disbelief and angry calls from parents and educators, said that in a typical suburban high school of 1,500 students, perhaps 50 are in need of treatment for drug-related problems and another 200 are using drugs on a regular basis.

Although drugs such as opium and cocaine have been an urban ghetto problem since the 20's or 30's, it is the youthful user that accounts for most of the dramatic increase in the past five years, police officials agree.

They also fear the trend of marijuana and LSD users toward heroin. Although the scientific data is inconclusive, statistical evidence exists to show that the emotional problems that lead one to use "soft" drugs also lead to narcotic addiction.

Although the magnitude of any social problem is larger in areas of population concentration, law enforcement officials are in agreement that even rural communities are not immune to the drug threat.

McCaig points to a recent State Police raid in Camden, an Oneida County village of less that 3,000 people. Ten youths were arrested for sale and use of a dangerous drug.

A recent raid in Oneida and Herkimer counties netted $5,000 in marijuana and hashish. Of the 33 persons arrested, 20 of them were 18 or 19 years old, three younger. One of those charged with selling was 14 years old.

"I have seen 17-year-olds clearing $500 a week peddling drugs," McCaig said. "Pushers are generally 14 to 20 years old," he said, generally because that is the age group of their customers.

The arrest statistics point up another feature of drug abuse: Although it is by no means confined to youth, some of the worst, and most hypocritical offenders are adults who misuse prescribed drugs, it is the young offenders that officials are most concerned about.

The number of individuals receiving help under rehabilitation programs funded through the Onondaga County Mental Health Department supports the contentions of law enforcement officials that the drug problem is serious and growing.

Chris Gianapoulous of Mental Health reports that about 60 individuals are in active contact with Direction toward Education in Narcotics, an agency that deals mostly with hard drug users on the south side.

Argosy house, a therapeutic community that deals with both "hard and soft" drug problems has between 15 and 20 youngsters in residence and is in active contact with another 50.

Aim at Pushers: Raids, arrests not sole solution to drug problem

Law enforcement officials are frank in admitting that raids and arrests are not the whole solution to the drug problem in Central New York.

Lt. Charles Delaney, who heads the narcotics squad of the Onondaga

County Sheriff's Department says, with a shrug, "I don't even know if arrests are really relevant to the problem."

Chief investigator James R. McCaig of the narcotics unit, State Police, Troop D in Oneida, states flatly that the effects of raids are blown out of proportion.

"We can cripple the traffic -- two weeks later it's back to normal. We can only hope that this type of operation will force the fringe to drop out," he added.

Both McCaig and Delaney point to a combination of education and enforcement, coupled with a change in public attitude, as the ultimate solution to drug abuse.

"Drugs are a symptom of another problem, not the core itself," Delaney said. "It's like blaming the fever for the cold. An inner or outer stimulus makes kids turn to drugs. It's a psychological or social problem."

Both law officers point out that there are common misconceptions about their roles. "We have to look to the community to see what they want." Delaney said.

"Three to four years ago we'd go out and arrest anyone with a nickle bag, now we're trying to get at the top, the pushers and suppliers." he added.

There are good reasons for concentrating on selective raids both officers point out. One is that they don't have the personnel to blanket the area and make mass arrests.

Delaney has three men including himself. McCaig didn't divulge the strength of his unit -- responsible for a seven county area -- but said if pushers realized how few agents he did have "they would be comforted."

Seek Source

"The raids are not for publicity," McCaig added, "if we made single arrests an agent's cover would soon be blown. We'd lose our chance at the course. If pushers knew the heat was on they'd leave town."

Another public misconception is the legal definition of "selling." Anyone who gives, lends, or takes money for even a small quantity of marijuana is technically guilty of "selling a dangerous drug."

There is a distinction between a "user-dealer" and a "commercial dealer" in the eyes of lawmen however. "If we knew there was a commercial dealer in town, we'd make an all-out effort to get him, drop everything else," Delaney said.

The "selective raid," as McCaig calls it, is designed to clear up a local drug ring, and if possible, lead to the source. An arrest in Central New York may result in series of arrests around the country.

A state police investigation in Syracuse, McCaig said, led to a raid on a lab in Boston, the arrest of a chemist and two assistants, and the seizure of $130,000 worth of Speed. Another drug arrest led to a cache of counterfeit money in Cleveland.

College campuses and high schools are often blamed for the presence of drugs in a community. Both officers said they would discourage such a generalization.

McCaig said he has seen some campuses that are a "haven," but not as a rule. He also doesn't think of campuses as a clearing house for a geographical area. In one investigation, a local high school student was found to be supplying the campus.

Critical Months Ahead

The community tends to forget about the drug problem when school lets out for the summer, Delaney said, yet these months may be the most critical.

"A college kid who's been blowing his mind regularly at school isn't going to come home cold. He will bring some stuff home with him or have a contact here," he said.

"If 'Joe' comes to town with a kilo of pot he bought for $25, by the time that stuff gets down to the high school students 81 people will have touched it and $7,000 will have exchanged hands," he added.

Organized crime does not loom as large in the drug scene as some would believe, McCaig said. The fringe of crime is on heroin and cocaine, but marijuana and LSD are too unprofitable. "Every user is a potential pusher. It is too competitive."

The reasons for using drugs are many, according to Delaney. "The curious and malcontent experiment with drugs, those not at ease, running out of fear or trying to identify."

Peer pressure can also be an important motivation . The "cool man" on the pedestal for a 15-year-old girl of a decade ago was the athletic star or the guy with the convertible, Delaney added, today he may be the acid head or pusher.

"We have to realize that times have changed," he continued, yet many youth "cannot look beyond the pleasures to the pain."

The schools are not the only place for drug education, McCaig stressed, the family is important too. "If a child has trouble with schoolwork or friends, if he begins drinking and smoking, the average parent can draw upon experience to counsel him."

"With drugs, few parents have the knowledge necessary for counseling. Parents who become frightened or hysterical make things worse. Some regard the first puff on a marijuana cigarette as addiction. This kind of attitude drives the kid to a friend who "claims he knows the score," McCaig added.

Both McCaig and Delaney were critical of the "Professional panic" that has greeted the drug problem. There are about 60 agencies in the area dealing with some phase of drug abuse, according to Delaney, resulting in many uncoordinated, though sincere efforts.

"This is a new ball of wax, that has grown in the last four years. I haven't seen any responsible education yet," he concluded.

Doctor reports drug-related county deaths

In New York City there have been more than 400 deaths from acute reactions to heroin and other drug-related causes since the beginning of the year. Medical and governmental officials fear that the trend will spread.

Heroin is the killer and should be the major target of any programs to combat drug abuse, according to Dr. William D. Alsever of the Syracuse University Health Service.

An assistant county medical examiner. Alsever said he gets "to see the other end of this -- the dead ones." Although nowhere near New York's epidemic proportions, there have been drug-related deaths in Onondaga County.

The local deaths are not publicized out of deference to the families of the victims. "I am often bothered by the decision not to draw attention to these incidents," Alsever said, "perhaps we should."

The drug problem is a complicated one "full of so many imponderables," Alsever continued. There are many gaps in professional education on dry drugs, just as there are many misconceptions among the general public.

Although he has been tabbed many times as a "local drug expert," he is quick to note that he isn't. "There are few who can claim a complete knowledge of drug abuse."

The heroin problem worries Alsever because of the dangers involved in its use and the difficulty of cutting off the supply. Customs officials are unable to prevent the inflow of the drug, he added.

"Heroin is the most profitable business I am aware of. Unless we can control the supply at the sources, Turkey, and the Orient, I don't see how we can stop it," Alsever said.

The threat of death from an overdose is only one of the medical dangers associated with heroin and other drugs that are injected. The occupational hazard of hepatitis, blood poisoning and tetanus accompanies use of a hypodermic needle under non-medical conditions.

Alsever said the "speed Kills" and "Meth is Death" claims generated by drug users themselves are somewhat overrated. Methadrine, a powerful amphetamine, carries nowhere near the dangers of heroin and other opiates.

"Heroin provides immediate and complete, albeit temporary relief from all pressures around you," he noted, making it attractive for those who want to escape from life.

Always a ghetto problem -- the reasons for an impoverished black in an urban environment turning to heroin are apparent, and to a degree understandable -- heroin has spread to the suburbs.

"Heroin is no longer an inner city problem," Alsever said. "You can now find it out in DeWitt or Marcellus," although many may find that hard to believe.

One misconception about heroin is that it has to be addictive. "Some people 'Joy pop' it -- inject small doses irregularly -- without becoming addicted," he pointed out.

High school and college kids may use heroin as a "downer" from bum trips on acid or from "Speeding," he added. In these applications it may or may not become addictive, although the users could easily become addicts.

Synthesized from morphine in 1896, heroin was quickly abandoned as a cure for morphine addiction when physicians discovered that they were simply substituting one addiction for another.

Many drugs in use today for non-medical purposes have, or had, legitimate medical uses, Alsever pointed out.

Although youth is the apparent target of anti-drug campaigns, many adults are just as guilty of abusing prescribed drugs through overdoses.

Pressed for a medical definition of "drug abuse," he said it would probably be "using drugs for nonmedical purposes including intentionally or unintentionally taking overdoses of any drug, illegally or legally."

Alsever relates drug abuse to alcoholism. Both are social problems, he said, and in terms of human lives lost, alchoholism may be more deserving of attention than drug abuse.

"Some of the money being spent on the drug problem may be better spent on the treatment of drunks and keeping them off the roads," he added.

One misconception that needs to be cleared up, Alsever said, is that every user of hard drugs or hallucinogens is an addict. "Many are dabblers, experimenters, or having a two to three year flirtation" with the so-called drug culture.

Come youthful drug users, he continued, should be placed in the category of a social drinker from a medical standpoint, according to Alsever. Others are "hooked, have bad heads, emotional problems, hang-ups."

Although some drug users are in need of psychiatric help, just because a kid uses drugs it doesn't necessarily mean he's a "scrambled character."

"Many adults in this community have to revise their attitudes about drugs -- to be conversant with the facts and get rid of myths. We have to update our information to be accurate and credible," he said.

Theories vary on solution of local drug abuse problem

Almost everyone who deals with the local drug problem decries the lack of education among professionals and the public. But theories on how to improve the situation vary.

Adults are targets for educational programs, specialists say, because of many misconceptions about drugs and drug addiction.

Junior High School and high school students are another primary target of drug education, because arrest statistics and school surveys indicate that age group as a critical one.

A survey by the North Syracuse School district a year ago and a more recent one in Syracuse city schools documented a dramatic rise in drug use and shocked a number of parents.

Michael Reagan, who chaired Mayor Lee Alexander's Temporary Commission on Narcotics Abuse and Addiction that led to the City-County Drug Advisory Committee is critical of the work that has been done.

Unconcern

"There is almost a malaise of unconcern by all our social and political institutions and by the general public that only recently, in this election year, is being broken by a series of short-sighted, hysterical public utterances and reactions," he stated.

He added "much of the data we have had we have distorted -- we've lied." A great deal of harm has been done by attributing false dangers to drugs and losing credibility among youth he said.

One active force in drug education is the State Narcotics Addiction Control Commission. The Syracuse office is responsible for an eight county area which includes Onondaga, Oswego, Cortland, Cayuga, Tompkins, Schuyler, Madison and Jefferson counties.

In addition to being a major supplier of pamphlets, films and speakers for school or community drug prevention programs, the commission funds local guidance councils and treatment centers.

Walt Rosendale, community representative for the commission admits it is poorly named. The goals are prevention, research, and treatment, all accomplished through education, he said.

The commission concentrates on educating educators, law enforcement officials, school children and adult groups on the facts of drugs and drug addiction, Rosendale said.

The reaction to drug education is varied, according to Rosendale. Some school administrators would rather ignore or cover up a problem than face it, he said, but most are cooperative.

The community councils are, he added, only as good as the people in them. There are 340 community councils statewide, with another 150 in some stage of planning.

Gerald Maywright, director of the Syracuse NACC office said many people have misconstrued "drug information with drug education."

"You can reach a saturation point with drug facts, our schools should spend less time on academics and more time on emotional values," he added.

The goal, Maywright said, should be to "turn kids onto themselves," so they won't have to turn to drugs as an outlet for their emotional problems.

Councils may be started by villages, towns, cities, and other governmental units. The NACC has provided reimbursement for the first $2,000 spent each year, and additional funds on a full or half reimbursable basis for professional services such as psychiatric or medical help.

Rosendale said the NACC aims at a truthful approach, disdaining the "scare technique." The literature is thorough and objective -- but there is no real gauge on how much effect it has. In any case, he notes, it provides an alternative to rumor and faulty advice.

NACC representatives have presented assemblies on drug abuse to children as young as third grade level. "We concentrate on values, role playing, and decision making," he said.

The youthful approach seems substantiated by the recent survey of students in Syracuse city and parochial schools. The survey included 15,140 students in grades 7 to 12.

Of those, 12.1 per cent, or 1,843 indicated that they had smoked marijuana, 6.5 per cent were currently smoking it. Four per cent, or 613 said they had used LSD and 3.1 per cent or 480 had used speed.

Perhaps most startling was the response from 1.1 per cent who indicated use of heroin, and 7 per cent, or 118 youngsters who admitted to The North Syracuse School District survey of February 1970 revealed that 18 per cent of the high school students and 6 per cent of the middle school students said they "would like to try marijuana if given the opportunity."

Many medical experts urge that youths be given sound medical advice, dosage information, and information on drug contamination to keep the death toll down.

These suggestions have met with resistance in many communities, since it would mean giving out information useful to the drug user in breaking the law, and could be construed as increasing interest in drugs.

Reagan, for one, is a fervent advocate of a strong central body, such as the City County committee, to control drug education, and to coordinate law enforcement efforts in the community.

The Committee membership has been criticized in some quarters because few of those named to it are drug experts, and most are busy men. Reagan justifies the choices on the grounds that such men as Sheriff Patrick Corbett and Chief Thomas J. Sardino are in positions of power, and can be expected to act on the problem.

Drug Councils give out facts to interested persons

One way in which area residents are combating the misinformation associated with drugs, and attempting to get at the causes of drug abuse, is through community narcotics guidance councils.

A number of councils already are operating in the Central New York area, with varying approaches to the problem and varying success.

Among the more established councils are groups in Baldwinsville, Camillus and Town of Salina. Although council chairmen get together monthly, each has developed its own plan of action.

Raymond Clover, chairman of the Baldwinsville council, sees his group's goal as preventive education and an attempt to provide counseling and treatment facilities on a local level.

Clover said he doesn't believe a neighborhood or small community should depend on an outside agency or higher government to solve local problems.

This philosophy pretty much sums up the function of local councils -- adults and youngsters pitching in with their time and efforts to pass around accurate information and lend a helping hand.

One of the most successful programs in Baldwinsville has been the sponsorship of "coffee hours" to disseminate information and discuss problems in an informal "non-structured, environment."

A group of 10 or a dozen residents gather at a host's home, and are joined by a few adults and teen-agers from the guidance council.

Literature and drug identification kits are available, but participants are urged to discuss anything they want, Clover said. The intimate atmosphere seems more conducive to frank questions and discussion than a large group, he added.

"Fears, prejudices, and dogmatic views come out in the open," he said, but knowledgeable people are there to argue with facts about drugs. Several hundred Baldwinsville area residents have already taken part in the coffee hour technique.

In addition to sharing in the coffee hours, youths are also used to staff the "hotline" on Friday and Saturday evenings. Anyone with a problem can call for counseling, referral, or just a sympathetic ear, Clover added.

Volunteers who work with the Baldwinsville council are versed in drug facts, and counseling techniques, in addition to their desire to help. Most have trained through the continuing education department at Syracuse University.

The Camillus Narcotics Guidance Council was formed one year ago, drawing upon the experience of Baldwinsville and other established councils.

Jack Gardener, its chairman, said the response within the community has been excellent, but the council members feel that it has taken a year to build public confidence and it will be years before the drug problem is under control.

The council operates a youth center in the village of Camillus. Staffed by a young couple, "the Town Shop" is open five nights a week, providing a recreational facility as well as a source of information.

A "counseling line" is maintained, with an answering service on a 24-hour basis. Council members are willing to try to find an answer to any problem: sex, family, school, emotional, or drugs. Troubled individuals are referred to professional counseling or treatment.

Like Baldwinsville, and the successful treatment centers in the area, the Camillus council refuses to divulge information to the police. The problems of credibility is great enough. Gardner noted, without risking any link with law enforcement agencies.

The Camillus council concentrates in six areas; adult education, youth activities, school education, after school programs, a drug education booth, and counseling.

The drug education booth, located in a shopping center, is staffed by high school students, with a young person from Argosy House on hand Saturdays.

Mrs. Pat Doupe, a mother of three, is a member of the Town of Salina Narcotics Guidance Council because she believes "you should be willing to work if you are going to shoot your mouth off about something."

Salina operates a youth-oriented coffee house as one of its projects. Although Mrs. Doupe believes most of the youngsters who frequent the coffee house "are just looking for a place to go," she feels it an important project.

Former addict aids others' return to society through Argosy House

Tony Gangone made the trip from a $50-a-day heroin habit, through a therapeutic community, to a position as community representative of Syracuse's Argosy House -- a hard row to hoe.

Candid about all aspects of the drug problem, Gangone admits that in a way he is glad he was hooked once, because the cure has given him insight into his own "emotional hangups" that he might never have attained under normal circumstances.

Gangone was the first graduate of Argosy House, which puts him in a unique position of seeing the therapeutic approach to drug rehabilitation and the problems of drug dependency "from the inside out."

Argosy House differs from other programs in the fact that drug dependency is attacked through its causes. The individual who undertakes the 12 to 18 month process is urged to progress through group dependency to confidence in himself.

According to Gangone and Harry Hulse, also an ex-addict, who acts as program director of the pioneer project, the basic cause of drug-dependency is fear and immaturity.

The fear, they added, can be of anything: failure, sexual inadequacy, the future, scholastic problems, loneliness, authority -- all of the human fears and shortcomings that plague everyone to a degree.

Other people may take to alcohol, food, or daydreaming as an escape route from their personal "hang-ups," or may continue through life without even realizing they have any problems. The addict took to drugs as an answer.

"When you take drugs it's great, but when you come down off them you're worse off than before, so you want to take them again," Hulse said. "The perfect avenue of escape can lead to total dependency."

"Drug abuse exaggerates one's character defects out of proportion. It's like a crack in a wall that you keep hitting with a sledge hammer -- nobody I know has become a better person through drugs," he added.

Physical addiction -- a need stemming from chemical imbalance caused by constant drug use -- is not the real problem according to Gangone. The mental and emotional dependence on drugs as a way out is the "real killer" he added.

Argosy House attempts to get an individual to cope without drugs. Talk therapy is interspaced with work therapy to instill a sense of responsibility, teach an individual his value as a person, and how to relate to other people, Hulse and Gangone said.

The process has a sound clinical basis, they added, and a psychiatrist is used on a consulting basis to diagnose problems too severe to respond to the treatment.

Not everyone has what it takes to complete the Argosy House course. Gangone explained. Because of limited space, applicants are screened for motivation before accepted.

Despite plans to expand, Gangone said, "even 100 Argosy House's are not going to do away with drug abuse, we can only hope to reduce the number of people involved."

Gangone and Hulse said they believe a lot can be done through the schools. Too much demand is being made in kids scholastically without helping them emotionally, they added.

"A teacher should be trained to spot the quiet kid in the back row who never says anything, the one with a family problem. Then they should be able to counsel him," Gangone concluded.

Two ex-addicts discover drug culture phony

The "drug culture" is a much publicized phenomenon that has sold records, clothing, books, magazines, making small or big fortunes for those quick to capitalize on it. It has also hooked a lot of kids on narcotics.

Charlie and Darryl see the psychedelic revolution -- drug culture bit as "phony." They have reason to know because they were once part of it.

"Kids want to believe a lot of things, like 'I saw God when I took acid.' Maybe they did, but the chemical they took didn't do it for them," Charlie said.

"The Peace-Love-Drugs thing is a farce," Darryl added. "Nobody really believed it, all they wanted to do is get high. It would be nice if it were true, but it isn't."

Charlie, now 21, got into drugs when he was released from a 19-month term as a youthful offender. He travelled around and went through the routine from pot to acid and speed, then heroin. "I was a hippie, if you want to call it that," he added with a shrug.

Darryl, 19, took another route to the same place. He was brought up in one of Onondaga County's wealthier suburbs, the son of a prominent family. In school he started with marijuana and glue, later got into pills.

"I was into pretty lightweight stuff," he said, "but I was emotionally addicted. If I ever needed something it was there but I was still a pretty messed up individual."

Both Charlie and Darryl ended up at Argosy House for therapeutic treatment. Charlie graduated from the storefront sessions, participating every day for a while, later a few times a week. Darryl has been in the Argosy House residence for 14 months and is about to graduate.

He said it's easy to look at the "drug culture" as a way of belonging, of finding friends. "I was out west and thought I had to maintain a 'slick image' because I was from New York. When somebody asked me if I wanted to try something, I went along with it."

The "culture" revolves around loving everyone, he added, "But if you're shooting drugs you're off by yourself. I wouldn't have admitted it then, but I thought I was the loneliest person in the world."

Outside images make you feel good about taking drugs, he added, "Like I'll take acid because of the war in Vietnam, it's nothing but an excuse."

Darryl tried marijuana while away at school. "Some friends offered it to me, I tried it, it gave me a good feeling, so I kept on trying things."

He said he can see things a lot more objectively now. "Society may create a lot of problems, but blaming it for drug abuse is an excuse, nothing more. It's still a kid's perogative."

"The biggest thing with upper-middle class people is they don't think they're messed up," Darryl added. Police, and parents in wealthy communities go out of their way to ignore the problem when there is one, he said.

"A friend and I were always getting into trouble," he noted. "We'd get picked up, taken to the police station, and let off. The police are always trying to coat something over where they should be involved. Whenever you have influential people, officials cater to them."

Darryl said he and his parents have been trying to get other kids from his area down to Argosy House. They have also tried to set up a store-front location in their village, but have encountered resistance. "They now regard my parents as radicals for trying to help," he added.

Both Darryl and Charlie encountered difficulty with their friends when they started going to Argosy House. "When they know you're clean and they're still on drugs they get uncomfortable, the scene never changes," Darryl noted.

Charlie thinks that the "drug culture" is getting to younger people. "The Peace thing is dying out, but drugs are expanding greatly. The kids we talk to that are 13 or 14 are impressionable. They've just got to experience something but they don't know where they are going.

"I was a dope fiend before I started using drugs," he noted. "I started robbing and switched to drugs. It was a substitute for selfish reasons, there were no inner changes in me."

Schools to start pilot plan for drug abuse education

A great deal has already been done to combat the drug problem in Central New York. The effect of this action is largely conjectural because the problem is a new one and insufficient data is available.

Of the six recommendations made by the Mayor's Temporary Commission on Narcotics Abuse and Addiction in Syracuse, specific progress has been made in a few areas and attention given to all of them.

State and local funds have been spent in the area of prevention and education, with more appropriated for new programs. Unfortunately, according to Dr. Donald D. Boudreau, Commissioner of Mental Health Onondaga County, "It's a gamble."

Boudreau is currently going ahead with plans for a $4 million drug education program to be implemented through the Board of Cooperative Educational Services, (BOCES) with the cooperation of the city, county and parochial school systems.

The pilot program -- first in the upstate area -- will be funded half through state appropriations, and half locally with "in kind services." It will be concentrated over the 1971-72 school year.

The funds were available some time ago, Boudreau explained, but they would have had to be used by Sept. 15. To go ahead and spend that amount this summer would have been "completely irresponsible," he added.

To encompass the entire spectrum of drug education, the plan will include training of teachers and students, providing counseling services in the schools, and instituting adult and community education through the school systems.

Although much planning has already been done, and much more remains to be done in the ensuing months, Boudreau admits. "We don't know what effect it will have . . . we are kind of betting that it is a reasonable program."

Any efforts to retard the rapid spread of drug abuse, he noted, is hampered by the gaps in research and statistical information on the problem. Part of this is due to the fact that drug abuse on a massive scale is a relatively new phenomenon. Another is the fact that it is illegal.

There is no real evidence that the problem has actually grown, he explained. More people are using drugs, but the possibility exists that this may represent a switch from alcohol. "Public health needs statistics," he added, but we can not get them yet."

Drug abuse existed in the late 1800's, Dr. Boudreau said, but it was not recognized as a problem. Most patent medicines contained narcotics, but their users were not identified as addicts.

The drug education plan Boudreau described, was one of the recommendations of the temporary commission. Another that has shown progress over the past few months is the establishment of a city-county coordinating council.

The recently named 16-member City-County Drug Abuse Commission is designed to act as a "board of advocates" on the problem, according to Dr. Boudreau.

Its stated purpose is to review programs in existence, act as a coordinating agency for all programs, serve as a clearing house for information and services, and as a sounding board for future programs.

The board will also stimulate new approaches for dealing with the drug dilemma. Its powers, Boudreau said, will be recommendatory and investigatory.

He added that the commission will not have the power of approving programs, but it can be expected that legislative and enforcement bodies, as well as independent agencies will be guided by their recommendations.

With the exception of administrative costs and the salary of staff members to serve the commission, the body should not add to the tax burden of area residents, he said.

Other programs recommended by the temporary commission which may reach fruition include speedy processing of drug cases in the court system, more response to treatment from the medical community and the mobilization of public concern.

Michael Reagan of the Syracuse University continuing education department noted that a final recommendation by the commission -- the creation of a central narcotics squad -- could run into a number of bureaucratic snags.

The only sane way for law enforcement officers to do their jobs, is to take the legalistic view, Reagan noted, but a central squad could be empowered to go after heroin dealers since that is the major source of death and criminal activity in the drug scene.

None of the commission's recommended programs are designed to interfere with the work already underway by public and privately funded agencies in the area, Reagan explained, but to coordinate them and pass along information valuable to them.

Direction in Education in Narcotics, DEN, and Argosy House are funded through local and state appropriations. DEN receives $60,000 a year, half from the state, and half locally, according to Dr. Boudreau.

Located on the South Side, it identifies hard drug users, refers them for treatment, and provides counseling and supportive services before and after treatment, he explained.

Argosy House is budgeted at $172,000 for 1971, half the bill picked up by the state, and another $67,000 by the county. Full time therapeutic treatment is offered hard and soft drug users, as well as counseling services.

The Mental Health Department is also responsible for the Methadone Maintenance Clinic at St. Joseph's Hospital, 100 per cent state funded at $160,000 a year, and works closely with the St. Mary's Detoxification unit.

Other services in the area, Boudreau noted, include the 1012 crisis center, and the many activities of individual schools and the community narcotics guidance councils.

More and more work is being put into finding a solution to drug abuse, although there is a variety of opinion on how to go about it. But specialists agree that it is an uphill battle and their efforts may go unrewarded for years.

THE PARADOX OF OUR SCHOOLS

Samuel Goldman*

"If all the city schools were closed, above my joy of being out of school, I would be very upset. My parents would also be very upset." Thus, wrote an eighth grader in the Syracuse City Schools in response to my inquiry as to what she would do if the schools ceased to exist. In a similar vein a tenth grader wrote, "I wouldn't mind for a while but you couldn't get very far without at least a high school education in our present society. I wouldn't be surprised if kids would be begging to get back to school after a while." An eleventh grader said, "At first there would be a sense of overwhelming joy. But after I thought about it, it wouldn't be so great. I would be bored to death after the third week."

These statements and others like them (400 students from grades 8-12 responded) seem to reflect the incredible paradox that our schools have become. Students seem to be saying, "We'd be happy if schools weren't there, but we can't live without them." A tenth grader put it more bluntly when he wrote, "Schooling is probably dumb, but necessary."

Professional school people also are impaled on a similar paradox. They come to their task with the challenge to build an enlightened citizenry and to open the doors to the riches of our society through equality of opportunity. Yet they soon find out that the gap between promise and delivery is an imposing barrier that is not easily overcome. Even those teachers who profess to know what must be done become disillusioned at the results of their efforts. In chorus with the students, these teachers seem to conclude that, "Schooling would be a great experience if it weren't for the schools."

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Why the paradox and how is it solved? The answer, of course, is not simple. As a matter of fact, one has to wonder whether an answer is even possible in light of the upheaval faced by our present-day society. But one thing must be clear: No one group alone -- students or professional schoolmen -- is the victim of this paradox. Focus upon one group at the expense of the other can only exacerbate an already bad condition and cause an unwarranted escalation from problem to crisis to disaster. A more viable approach is to examine the nature of their school lives to see how this contributes to the school paradox.

Even the most cursory examination reveals the existence of two school lives for both the students and the teachers. Their "business lives" are related because of the organizational expectations each has for the other. Their "human lives" seldom interact since they are viewed, primarily by the teachers, as being personal and outside the organizational expectations of the school. Cusick, in his recent study of a high school, points this out.

> Teachers' behavior both within and without class, seems to discourage mutual interaction. Having been hired to influence and instruct students, a teacher at Horatio Gates feels he has two ways in which he can operate. He

> can either get close to students and carry on his work within a personal relationship or he can present himself as a "subject matter specialist" who avoids interpersonal contacts and keeps his body of knowledge between him and his students.
>
> ...most teachers choose the second option.[1]

As a consequence students come to view teachers as remote, unfeeling and uninterested. The teacher becomes a source of information to be turned on-and-off as needed. For the most part, teachers are irrelevant as human beings and the student must turn to his peers to meet his personal and human needs.

Teachers also come to view students in certain ways. Students are in school to learn and the teacher's role is to pass on the information they must have. Schooling is deemed successful to the degree that students feast happily and productively on this information. Personal human relationships are not necessarily part of this feast and therefore they may seldom, if at all, be served with it.

Thus co-exist the school lives of the two major participants in the schooling process. The "business lives" intersect (some critics say tenuously) while the "human lives" pass each other by as though they were parallel bars. The cry for human interaction between student and teacher goes largely unmet since it can find no way of becoming part of the definition for school organization. Indeed, it may well be said that the paradox described earlier is nurtured almost entirely by the fact that schools are organized and operated to preserve the business life and that they are governed by a "passing-down-knowledge" principle which mitigates personal human interaction.

Let us briefly examine this principle. Schools are organized vertically with administrators at the top, teachers somewhere near the top and students at the bottom. Teachers are expected to be subject matter specialists whose major preoccupation must be with passing down the knowledge of the specialty. Rigid schedules (especially in the secondary schools) force students to move about several times during the school day in order that they may come in contact for a specified number of minutes with one specialist after another. Rules and regulations enforce student compliance to a herding process that moves students efficiently from place to place. The entire principle is lubricated by a reward system that is future-oriented ("Learn now; enjoy the benefits later."), manifesting itself through diplomas, admission to college and good jobs.

Teachers who follow the business life and adhere to the "passing-down-knowledge" principle are seldom discouraged from this orientation. They and their students go about their school lives seriously but dispassionately; when a human need goes unfulfilled, both wonder why schools can be so bad.

One can only speculate as to what would happen if the organizational paraphernalia that engulfs both student and teacher were removed or significantly altered. Would students learn less? Would the teacher role be negatively compromised? Would different relationships emerge between teacher and student? Would the school paradox disappear?

There is some evidence which suggests tentative, affirmative answers to these and related questions. More research is needed. But action is also needed now before numerous young people "tune out" and are lost to our schools. The evidence is strong enough to suggest that at the very least organizational barriers to human interaction need to be pulled down. Students and teachers must find ways of bringing their human as well as their business lives more closely together in the school setting. Both must work together to solve the school paradox. The quality of school life depends on it -- and so does the schooling of our future generation of young people.

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PRESENTATION AND IMPLEMENTATION OF A DRUG ABUSE PREVENTION PROGRAM

Sol Gordon*

The critical need in a program to curb drug abuse is a strategy of communication: a way of getting young people to listen. This can be accomplished only if the presentation and implementation of the program is factual. And, to be effective, it must be presented in the language of the users and potential users.

It has been observed that most prevention campaigns fail because of outright lies, distortions of the facts and general confusion on the effects of drugs.

There is always some danger that publicity will stimulate interest in drug-use; on the other hand there is a definite need to clear up the confusion that has followed in the wake of the current hysteria about drugs.

However, scare propaganda is not the answer. It may appear to work sometimes with parents, but in the eyes of young people it does nothing for the credibility of the people putting out the information.

For instance, it is likely that overdoing the "dangers" of marijuana or hashish alienates young people very quickly. The fact is we don't know whether marijuana is in itself a harmful substance. We do know that occasional use by a socially adjusted youngster causes no apparent harmful side-effects and, as a matter of fact, its use may just result in mild euphoria. Of course, adverse psychological reactions may occur in some people just because the drug is illegal. Many psychologists feel that the chief problem with marijuana is that it is illegal.

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On the other hand, there are many drugs circulating through America's "drug culture" that are known to be dangerous. These include opium, LSD, heroin, barbiturates, amphetamines -- to name a few.

In all circles, there is confusion about these drugs.

For instance, a person is done no favor by being assured that he will become addicted on heroin after the first dose. Because he is being told something that is untrue 99 per cent of the time; authoritative credibility with him is damaged, particularly if he tries it and finds that he is not addicted.

He is done a favor if he is told that he risks infectious hepatitis due to unclean injection paraphernalia and that the more often he uses it the more likely he is to become addicted.

He could be helped if he could be convinced that there is no way these days to tell whether he is buying pure LSD, or some witch-doctor concoction, or insecticide. He is not helped if he is told all the lurid effects of LSD without acknowledging that many people have had pleasant experiences. It could be helpful if he is told that there is no way to tell whether the next drug-induced experience will be unpleasant. And perhaps most important, young people need to know that treating their psychological problems with any drug, including alcohol, is risky business. The usual effect is an initial period of euphoria after which the anxiety and depression increases and the initial problem is magnified -- sometimes catastrophically.

Amphetamine-based drugs come in a wide variety of legal and illegal forms and with a wide variety of slang-terms associated with them. The detrimental effect of relying on slogans to communicate can be appreciated by considering a survey this writer made of 125 Upward Bound students: All had heard that "speed kills." Yet, not a single youngster knew what speed is, even though 20 per cent were using it under other names (including "blue-jackets" and diet pills).

Of course, these are only a few representative difficulties. A lot of work needs to be done in this area, including some considerably realistic research.

In a Syracuse-based community newspaper ("Priority One News", March 12, 1971) an editorial by a young man of this writer's acquaintance makes the following points:

> In attempting to deal with its problems, society often gets caught in the trap of settling on cliched solutions. At present, worry and concern about extensive drug use and abuse has led people to "drug education" as the great panacea for solving problems with youth.
>
> There is no doubt that the issue of drugs is a serious one and that education is a viable means of dealing with the problem. Nevertheless, two things have kept drug education programs from being as effective as they might be. First is the mistaken assumption that kids are ignorant about drugs. To the contrary, most kids are knowledgeable even though they may not always be factually correct. If the goal of drug education is to inform the ignorant, then a greater emphasis should be put on adult education since most parents are less familiar with drugs than are their children.
>
> The second aspect which has kept drug education from being effective is the tendency to moralize or tell half-truths. It is very difficult to convince a person that marijuana is bad when he has had good experiences with it. Likewise, to tell a person that marijuana causes aggressive or violent behavior when he knows both from experience and research literature that this is not the case, severely undercuts the credibility of anything else that agency or program may say.

> This critique of drug education is not an endorsement for drug use, but rather an attempt to point out reasons why such programs have not been successful in dealing with the situation.
>
> When the public becomes concerned about a problem, it demands quick and simple answers. The danger with cliched solutions, however, is that they often obscure their own value by oversimplifying. The issue of drugs and why people use them is not a simple one and despite what the public may want to believe, there are no simple answers. Drug education will become effective only when this fact is understood.

It is widely acknowledged that educational efforts made by high schools throughout the country to curb drug abuse have failed. As a matter of fact, very close observation of several high school programs leads this writer to believe that drug usage increases after such programs. The credibility gap as a factor when authority figures such as "narcs," physicians, and other experts talk to students has been discussed in a number of articles. What is not generally known is that widely heralded programs of youthful ex-drug addicts addressing assemblies also alienate students. These groups tend to make stereotyped presentations and invariably take a stronger position on marijuana than even "authority" figures. ("Let me put it to you straight man, I started on marijuana and look what happened to me", "We all started on marijuana...," and so forth.) It is also beginning to dawn on people that many ex-addicts have no other profession than being "ex-addicts" -- not a very commendable model.

The apparent reduction of LSD intake seems to be unrelated to educational drug abuse programs, but does seem to be due to increasing actual experiences of youth with "bad trips" or witnessing such "trips" among close friends.

Another important consideration is that youth do not respect moralizing even by their heroes. Despite "Madison Ave." type advertising using pop singers, sports figures, and so forth, warning against drug use, individual behavior seems unaffected.

The Miami Herald (September 7, 1970) contained the following not widely circulated UPI report (quoted in its entirety):

> HEW ISSUES DRUG REPORT
>
> Kick-the-habit drug abuse projects are doomed to failure if they set abstinence as a goal, a Health, Education and Welfare Department report says.
>
> "It is safe to predict that despite anyone's efforts, drug use will not disappear in the foreseeable future," said the evaluation of nine HEW-supported drug abuse projects.
>
> "Consequently, to set abstinence as a project goal is to foredoom the project to failure."
>
> The report, released over the weekend, was issued with a disclaimer that HEW does not necessarily endorse its conclusions. The report was written by Richard Brotman and Frederick Suffet of New York Medical College.
>
> They evaluated projects for drug users in Oakland, Calif., Denver and two in New York City, and five training and research programs.
>
> Projects that set abstinence goals failed because many young drug users, especially marijuana smokers, do not share the belief that drug use is wrong and harmful, the authors said.
>
> They cited an Oakland program where the directors reported failure because the young people rejected their arguments that drugs lead to poor health, broken homes and limited career opportunities.
>
> Abstinence-directed projects also failed because they are too narrow, the authors said.

> "If an occasional marijuana user experiences severe discord with his parents because they have discovered his marijuana use, then the first priority should be assigned to repairing the family relationships and not necessarily to obtaining from the youth a public declaration that he will refrain from smoking marijuana," they wrote.
>
> The projects all were intended to reduce glue-sniffing, marijuana smoking and use of heroin and amphetamines. Their subjects were sometimes as young as 10 years old.

The New York Times (November 24, 1970) contained the following UPI news article (an excerpt):

> ADS ARE BLAMED FOR PILL OVERUSE
>
> Two doctors blamed Madison Avenue image makers today for enticing Americans to take pills for every imaginable purpose, including "sometimes utterly ridiculous reasons."
>
> "In uncounted advertisements we are being told, persuaded and conditioned not to accept any minor discomfort," Dr. J. S. Gravenstein of Case Western University in Cleveland testified before a Senate subcommittee.
>
> "We are continuously bombarded to take drugs for sometimes utterly ridiculous reasons. We are cajoled to pop a couple of pills into our mouth to get fast, fast relief, freedom, pleasure, sleep, comfort, relaxation and regularity.
>
> "The consumer is continuously urged to take drugs. Consequently, he demands drugs also from his physician."
>
> With such "pernicious, irresponsible, advertising," Dr. Gravenstein said, "we should not really be surprised when our young people adopt this belief and seek their own drugs to cure their own discomforts, imagined or real."
>
> Dr. Gravenstein and Dr. Sidney Merlin of the New York State Department of Mental Hygiene were critical of hard-sell tactics used by drug companies.

An article in the March 14, 1971, issue of The New York Times reemphasized the growing concern of the Federal government regarding the media encouraging the use of "mind affecting" drugs:

> GROWING USE OF MIND-AFFECTING DRUGS WORRIED F.D.A.
>
> The mushrooming promotion, prescription and use of mood and mind-affecting drugs -- stimulants, sedatives, tranquilizers and the like -- are drawing critical scrutiny from the Federal Government and the medical profession.
>
> The Food and Drug Administration, a spokesman said in an interview, began studying the problem three months ago because it was "thunderstruck" by the number of advertisements in medical journals that seemed "to go way overboard."
>
> He said the agency was concerned about indiscriminate use of psychoactive drugs without adequate knowledge of their long-range effects...

I have in my possession a collection of hundreds of pamphlets, books, and articles on drug abuse published in the last two years. Only two or three articles direct their attention to the problem of communicating to youth in ways that do not alienate them.

Among the most useful publications that I have seen are distributed by the National Clearinghouse For Drug Abuse Information (among them "Answers to the most frequently asked questions about drug abuse" and "How to plan a drug abuse education workshop for teachers.") Their pamphlets can be employed effectively providing that we take seriously the most important reasons why young people use drugs. The following list is included in "Answers to the most frequently asked questions about drug abuse":

1. The widespread belief that "medicines" can magically solve problems.
2. The numbers of young people who are dissatisfied or disillusioned, or who have lost faith in the prevailing social system.

3. The tendency of persons with psychological problems to seek easy solutions with chemicals.
4. The easy access to drugs of various sorts.
5. The development of an affluent society that can afford drugs.
6. The statements of proselytizers who proclaim the "goodness" of drugs.

As I see it the problem is at least, in part, one of effective communication and new directions in treatment.

There should be three main objectives in a drug abuse program:

1. research
2. communication of the findings to both youngsters and professionals interested in prevention and in helping youngsters with drug problems.
3. with an enormous number of youth already heavily involved in drugs, we need also concern ourselves with the best therapeutic approaches for intervention, for change, and for rehabilitation.

In my judgment no drug abuse program operating outside the context of improving conditions under which a drug culture will flourish will have significant impact. Thus, students and teachers need to be able to broaden the scope of any "abuse" program to include improvement of the general climate of the school or community.

DRUG ADDICTION

Edwin M. Schur*

THE "DOPE FIEND" MYTH

In recent years there has been considerable repudiation of the once prevalent "dope fiend" myth[1] -- which depicted the drug addict as a degenerate and vicious criminal much given to violent crimes and sex orgies. More and more people are coming to understand the nature of opiate drugs and the meaning of addiction. This discussion will be concerned primarily with that class of pain-killing and soothing drugs derived from or equivalent to opium. Morphine and heroin are the best known of these drugs; others include codeine, meperidine (Demerol), and methadone (Amidone, Dolophine). Such pain-killers are the drugs of choice of most persons who are fully addicted in the sense described below. This is an important point, because the continued use of these opiate-type drugs (to which the term *narcotics* may also be applied) produces characteristics and behavior quite at odds with stereotyped conceptions of the dope addict.

Effects of Opiates

Central to the various common misconceptions is the belief that the addict is dangerously "hopped up." Actually, opiates are depressants--that is, they produce a general lowering of the level of nervous and other bodily activity. The effects of these drugs have been summarized as follows:

> The depressant actions include analgesia (relief of pain), sedation (freedom from anxiety, muscular relaxation, decreased motor activity), hypnosis (drowsiness and lethargy), and euphoria (a sense of well-being and contentment).[2]

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* Edwin M. Schur, *CRIMES WITHOUT VICTIMS: Deviant Behavior and Public Policy, Abortion, Homosexuality, Drug Addiction*, copyrighted 1965. This section of the book is reprinted by permission of Prentice-Hall, Inc., Englewood Cliffs, N.J. Dr. Schur is Professor and Chairman of the Department of Sociology at Tufts University and Associate Editor of the *American Sociological Review*.

Although the relation between addiction and criminality will be examined, there is nothing about the operation of these drugs which would incline a user to commit criminal offenses. In fact, the specific effects of opiates, serve to decrease the likelihood of any violent antisocial behavior. Similarly, opiates produce a marked diminishing of the sexual appetite--long-term addiction producing impotence among most male addicts; hence, concern about "dope fiend sex orgies" is quite unfounded. Indeed, perhaps the most striking characteristic of addicts is their general inactivity--on the basis of which they might be considered unproductive or withdrawn but hardly fearsome.[3]

It has also been widely believed that opiates produce definite and extreme organic disturbance and deterioration in the users. Yet, as an authoritative report recently emphasized, there are no known organic diseases associated with chronic opiate addiction--such as are produced by alcohol addiction, regular cigarette-smoking, and even chronic overeating. Although opiate use does produce such effects as pupillary constriction, constipation, and sexual impotence, none of these conditions need be fully disabling, nor are they permanent.[4] Similarly, many characteristics and ailments, such as unkempt appearance and symptoms of malnutrition, which often are exhibited by addicts in our society, are attributable to the difficulties they experience in obtaining drugs rather than to the drugs' direct effects.

There is also considerable misunderstanding about the supposedly positive feelings the addict receives from the drugs. As noted above, a sense of well-being and contentment is often produced by opiates. As a young female addict has put it:

> You simply do not worry about things you worried about before. You look at them in a different way.... Everything is always cool, everything is all right. It makes you not feel like fighting the world....I mean it's that sort of a thing, you know, when your *not* hooked.[5]

Some discussions of addiction have exaggerated the positive nature of these euphoric effects, and this has led to the widespread belief that addicts take drugs solely for "kicks." The crucial misunderstanding is suggested by the addict's express limitation of the above description of euphoria to when you're not hooked. In most cases, positive feelings about the drug are largely restricted to the early stages of addiction. In the later stages, a reversal of effects occurs, in which the drug is no longer taken primarily to obtain positive pleasure but rather to avoid the negative effects of withdrawal.[6] As the addict just quoted goes on to say, the user's feeling about the drug changes drastically once real dependence upon it is reached: "Suddenly, the character of taking off /‾injecting the drug_7 changes ...all you're trying to do is keep from getting ill, really...."[7] Indeed, the theory of "kicks" may be inadequate even when applied to the early stages of addiction. As one major research report has noted, the "kicks" adolescent addicts seek may reflect their overwhelming general unhappiness. To the extent that the drug combats this unhappiness, it primarily offers relief rather than positive pleasure. The same report also refers to interesting laboratory findings of wide variation in individual responses to an initial injection of opiates. These data suggest that even if such drugs tend to produce some euphoria, the nature and extent of this feeling may be greatly affected by the user's personality characteristics.[8]

The Addiction Process

The process of becoming addicted involves a developing bondage to the drug. According to a World Health Organization definition:

> Drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose; (3) a psychic (psychological) and generally a physical dependence on the effects of the drug; (4) an effect detrimental to the individual and to society. [9]

The term intoxication may not be the most appropriate to use in describing the effects of opiates, and there is at least some dispute about the nature and extent of detriment necessarily associated with addiction. However, the rest of the definition does highlight the crucial features of the addiction process. Tolerance and dependence are the characteristics which distinguish the confirmed addict from other drug users. Tolerance refers to the process through which the body adapts to the effects of a drug. Because of such adaptation, the dose must increase in size if the same effects are to be produced; likewise, with the growth of tolerance the drug user becomes able to safely take doses which might be dangerous or even fatal if taken by a nonuser. It is important to note that addiction exhibits a tendency to increase the dose. As will be seen, there is considerable dispute about whether this tendency is virtually unalterable or whether it is possible for some addicts to be maintained on a stabilized dose.

Once tolerance to opiates reaches a certain level, a distinct physiological (as well as psychological) dependence on the drug is produced. When this dependence has developed addiction is complete and the user is properly referred to as an addict (although the term addict sometimes has been used more broadly to cover regular use even of non-dependence-producing drugs). The user's bodily system now, in effect, requires the drug to function smoothly, and if it is withdrawn the addict experiences acute symptoms of distress, known as the "abstinence syndrome." This syndrome includes a variety of both somatic and psychological symptoms, the severity of which is directly related to "the nature of the narcotic, the daily dosage used and the intervals, the duration of the addiction, the rapidity with which the drug is withdrawn, and the intensity of psychic and somatic dependence. It is inversely related to the resistance, vigor, and well-being of the addict." As this same report notes, despite the likely variations just indicated, "all recent authorities agree that the withdrawal syndrome has an organic basis."[10] It also seems clear that withdrawal of the confirmed addict from drugs is always at least an extremely unpleasant experience. Although in some cases the physical symptoms (which reflect disturbances of the neuromuscular, gastrointestinal, and respiratory systems) may be no more severe than a bad case of the flu,[11] in other instances the addict may be acutely and violently ill. And the psychological impact of the experience should not be overlooked:

> I thought I would go mad. I was on the verge of insanity. I prayed for help, for relief, for death. My clothes must have been wet with sweat. I cursed the habit. If anyone could have seen me they would have thought I was a raving maniac.[12]

The phenomena of physical dependence and withdrawal distress are important to an understanding of the addiction problem. However, it would be a mistake to think that physical dependence fully explains the confirmed addict's need for drugs. Any individual administered opiates in sufficient dosages over a long enough time will, when administration is stopped, experience withdrawal distress. Thus many persons receiving such drugs in the course of medical treatment for the relief of pain become addicted to them. Yet not all such individuals revert to drugs after withdrawal. The term drug addict is ordinarily applied to those persons who, over some period of time, feel the "overpowering desire or need (compulsion)" mentioned in the WHO definition; a recent study has employed the term craving in discussing this important aspect of addiction.[13]

At the same time, the fact that the long-term addict has a physiological as well as psychological need for his drugs helps to put his condition and his behavior in proper perspective. Dependence also provides a basis for distinguishing truly addictive drugs from those which may be said to be only habit-forming--or to which users ordinarily develop merely a psychological habituation or dependence. Tobacco and coffee would be good examples of such habituating drugs. Stimulants such as cocaine, marihuana, and peyote (mescaline and LSD are similar) may produce striking effects on the users and sometimes strong psychological habituation, but they are not truly addicting. Amphetamines (such as Benzedrine) also fall into this category. Barbiturate drugs can, in prolonged use, lead to actual tolerance and physical dependence, but despite the danger of such addiction the medical use of barbiturates (primarily to treat insomnia) is widespread and socially approved in our society. Similarly, social approval of alcohol exists in the face of the well-known dangers of excessive drinking. Many experts insist that the condition of alcoholism is far more harmful to the individual than is opiate addiction. The unhappy lessons of the Prohibition experiment point up the key role negative social sanctions on drug use may play in creating secondary problems.

CAUSES OF ADDICTION

According to a large body of psychological and psychoanalytic literature, addiction is but a symptom of an underlying psychic disorder, and certain types of individuals are psychologically predisposed to drug addiction. Despite variations reflecting different schools of psychological theory, psychologists and psychiatrists seem to agree on one central point--that the personality type typically exhibited by addicts involves strong dependency needs and pronounced feelings of inadequacy.[14]

Sociologist Alfred Lindesmith, who highlighted the popular misconceptions embodied in the "dope fiend" myth, also provided a detailed critique of the psychiatric approach to addiction. He was especially disturbed by the prevalent diagnosis of the addict as a "psychopathic personality" or as a person with "psychopathic diathesis or predisposition." One early and influential report, for example, had found that 86 per cent of the addicts studied had been affected "with some forms of nervous instability before they became addicted" ...the largest category comprising "care-free individuals, devoted to pleasure, seeking new excitements and sensations, and usually having some ill-defined instability of personality that often expresses itself in mild infractions of social customs."[15] Lindesmith insisted that an inordinate emphasis was being placed upon the gratification the addict supposedly received from drugs and insufficient attention paid to his need to avoid withdrawal distress. His basic criticism, though, was that the psychiatric approach failed to develop a specific, self-consistent, and universally applicable theory of addiction. It evaded the problem of explaining how some psychologically "normal" persons (14 per cent in the study cited) become addicted. Nor did it explain cross-cultural and group variations in addiction rates. Early diagnostic studies, furthermore, made no use of control groups of non-addicts, so a finding that 86 per cent of the addicts were psychologically disturbed could not really be evaluated. Even the use of control groups, however, would not remove the objection that the psychologists used as subjects only those who were already addicted--and in many cases, for many years. Such studies do not distinguish those traits which were the result of addiction from those which had caused it. Finally, Lindesmith contended, the very fact of addiction led the psychiatrist to find some underlying psychic difficulty. He noted the apparent tendency of psychiatrists to treat almost any trait exhibited by an addict as a possible indication of psychopathology. Thus some cases of addiction were held to be caused by lack of self-confidence; others by the pleasure-seeking drive of carefree individuals. He concluded: "The addict is evidently judged in advance. He is damned if he is self-confident and he is damned if he is not." [16]

On the basis of his own extensive interviews with addicts, Lindesmith developed what is perhaps the only distinctly sociological theory of addiction. He took as his goal an explanation that would include all cases, on the assumption that the only true causal explanation is one that is applicable to all instances of the phenomenon being explained. (This approach is rather different from that employed in most sociological research, where association between variables usually is stated in terms of probability--that is, statements are made about the likelihood of certain events, based on statistical outcomes in past observation.) Lindesmith began his research with a working hypothesis, which he revised to take account of negative cases wherever he encountered them. His final thesis, to which no exceptions could be found, was that "the knowledge or ignorance of the meaning of withdrawal distress and the use of opiates thereafter determines whether or not the individual becomes addicted."[17] This refers to the persistence of a craving for the drug after withdrawal; continued use may result in physical dependence, regardless of the presence of this knowledge.) Essentially what this explanation provides is a retrospective description of the learning process through which all addicts go. A major criticism of the theory has been that it does not afford a basis for predicting which particular individuals will become addicted. Although this criticism seems partly warranted, Lindesmith's thesis has the merit of calling attention to the important element of learning involved in becoming an addict, and of suggesting that anyone could be susceptible to such a learning experience. (As another writer notes, in the current American drug situation this learning process involves not only knowledge of withdrawal and dependence but also important changes in the individual's over-all self-concept, gradual preoccupation with the need to obtain drug supplies, and likely involvement in a drug-addict subculture.[18]) Howard S. Becker's processual analysis of marihuana use has described the way in which, with that drug too, one learns to become an habitual user.[19]

Another approach to the causes of addiction lies in the extensive findings from research into the nature, extent, and distribution (spatial and social) of narcotics use in various large metropolitan centers. These area studies derive, in part, from the ecological approach developed some years ago by the Chicago school of sociologists. Indeed, it had already been found by Faris and Dunham in their classic study, Mental Disorders in Urban Areas (1939),[20] that in Chicago at that time addicts were highly concentrated in the deteriorating and generally disorganized "zone in transition" near the center of the city. Recent studies in New York, Chicago, Detroit, and other large cities show a persistent and clear relationship between ecological structure and the distribution of known addicts. Addiction is invariably found to be concentrated in those areas of the city that are most dilapidated and overcrowded, inhabited by persons of low socioeconomic and minority-group status, and characterized by high rates of other types of social pathology. One writer notes: "Such ecological studies of drug-users known to courts and hospitals reveal a higher degree of concentration of teen-age drug-users than is found for almost any other type of psychological or social problem."[21] This type of research has also disclosed the emergence in the larger metropolitan areas of a distinctive addict subculture.

A recent report has summarized the large body of data obtained in a ten-year study of juvenile drug use in New York, undertaken by the Research Center for Human Relations at New York University. This research, conducted under the guidance of social psychologists, combined an interest in the dynamic psychology of the individual deviant with an awareness of the importance of the socioeconomic and even legal aspects of the drug problem. The findings indicated that the areas with the highest drug use were those that were most overcrowded, had the highest poverty rates, and were populated largely by minority group members.[22] Not only was drug use found to be correlated with significant socioeconomic variables of that sort, but the New York researchers also concluded from an attitude survey that the high-use neighborhoods were characterized by a cultural climate conducive to experimentation with drugs. (They found a pervasive outlook on life which might be summarized as pessimistic antisocial hedonism.[23])

A major theoretical problem for such studies is posed by the fact that not all individuals in the areas of addict concentration take up drugs or even orient themselves to this dominant cultural climate. In seeking to explain the nonusers in high-use neighborhoods, Chein and his associates revert in some degree to a psychological-predisposition approach. They note certain functions the use of drugs may serve--such as relieving various personal and interpersonal strains and in general "establishing distance from the real-life demands of young adulthood."[24] A comparison of the family backgrounds of a group of addicts with those of a group of nonaddicts suggested that such background might constitute the basis for susceptibility to addiction. The unstable and disharmonious family milieux in which the addicts were reared contributed, they felt, to "the development of weak ego functioning, defective superego, inadequate masculine identification, lack of realistic levels of aspiration with respect to long-range goals, and a distrust of major social institutions." They also found that the fathers of the addicts had either been absent much of the time or were themselves highly disturbed or deviant.[25]

Limits of the Causal Approach

These findings may suggest some of the practical limitations of past and present studies of causes of addiction. It is not too difficult to summarize these findings in a very general way. To begin with, it is now known that there is no single "type" among addicts--the physician who succumbs to addiction, for instance, is a quite different type sociologically (and perhaps psychologically) from the poverty-stricken minority-group member enmeshed in a delinquent and addict subculture. However, individuals in certain socioeconomic categories run a relatively greater risk of encountering and using narcotics than do those in other categories. Also, it seems likely that of those individuals in the high-risk categories it is the more troubled or the more disadvantaged, situationally, who are especially likely to take up drugs. (Although in another sense they could be viewed simply as those most fully socialized into the prevailing, if deviant, pattern.) The specific policy implications stemming from conclusions of this sort are not very clear. On the one hand it seems that addiction is partly caused by other general social disorderss and that one way to deal with it is to attack the various socioeconomic ills which constitute the breeding ground of drug use. Similarly, various types of family life are highlighted as being detrimental, and presumably measures should be taken (assuming it could be determined just how this might be done) to improve the quality of interparent and parent-child relations. And if those individuals who do become addicted have certain personality problems, some kind of therapy or counselling should be aimed at treating the addicts themselves.

It seems clear that pursuit of all these types of treatment is desirable. At the same time, in the absence of any theoretical or therapeutic breakthrough that could be expected to result in a high rate of prevention or "cure" (the relapse rate in addiction cases is extremely high), it may be useful to approach the question of addiction in a somewhat different way. Whatever the causes of individual cases of addiction, the broader dimensions of the addiction problem may be amenable to improvement through variations in public policy. As one expert has stated:

> The prevalence and consequences of addiction in any society depend as much upon the social and legal definitions placed upon the non-medical use of narcotics as upon the nature and effects of narcotics or the nature of the persons who become addicted.[26]

To some observers, attempted reforms of the legal policies on addiction never reach the core of the problem. Indeed most psychologically oriented students of addiction maintain that, without individual treatment, persons succumbing to addiction would -- even in the absence of drugs -- be involved in some kind of problematic behavior. Yet few responsible students of the problem view psychological treatment of susceptible individuals as offering a complete solution of the addiction problem. Attention to narrowly defined causes cannot lead to a full understanding of addiction as a social problem. Such an understanding requires consideration of the legal policies which define and seek to control that problem.

DRUG LAWS AND ENFORCEMENT

Narcotics Legislation

The practical effect of American narcotics laws is to define the addict as a criminal offender. This result has stemmed largely from the interpretation given the Harrison Act passed by Congress in 1914. This law requires registration of all legitimate drug-handlers and payment of a special tax on drug transactions. It thus establishes a licensing system for the control of legitimate domestic drug traffic. In this respect the Harrison Act has been extremely successful, and it seems clear that originally the statute was intended merely to serve this function. It specifically provided that the restrictions would not apply to dispensing of narcotics to a patient by a physician "in the course of his professional practice" and "for legitimate medical purposes." As a recent and authoritative report concludes: "Clearly, it was not the intention of Congress that government should interfere with medical treatment of addicts."[27] Yet, through a combination of restrictive regulations, attention only to favorable court decisions, and harassment, the Narcotics Division of the U. S. Treasury Department (and its successor, the Federal Bureau of Narcotics) has effectively and severely limited the freedom of medical practitioners to treat addict-patients as they see fit--in particular, to provide addicts with drugs when that is believed medically advisable.

An early test of the Act came in 1919 (Webb v. U.S.). The facts showed flagrant abuse of the law by the defendant, Dr. Webb, who had sold thousands of narcotics prescriptions indiscriminately, for fifty cents apiece. The government, however, presented the issue to the U.S. Supreme Court in the following form:

> If a practicing and registered physician issues an an order for morphine to an habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use, is such order a physician's prescription /_under the specific exemption in the Act_7?

Accepting this restrictive definition of "professional treatment", the Court asserted that "to call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required."[28] Another case three years later (U.S. v. Behrman) also involved obvious abuse of the Harrison Act; here the doctor had given to an addict a huge quantity of narcotics for use as he (the addict) saw fit. In what one student of these decisions[29] has termed a "trick indictment," the government glossed over the doctor's quite evident bad faith, acted as though the drugs had been provided in good faith for the purpose of treating the addict, and obtained a ruling to the effect that any such wholesale prescriptions (in good faith or not) violated the law. At the same time, however, the court indicated that the prescription of a single dose or even a number of doses -- made in good faith -- would not be punishable under the Act.[30]

To this day, the Federal Bureau of Narcotics quotes with approval the Webb and Behrman decisions, making little or no mention of an important

1925 ruling (*Linder v. U.S.*) which would seem to challenge and greatly limit these earlier judgments. In the 1925 case, the government prosecuted a well-established Spokane physician who had prescribed a small amount of narcotics for a patient who was actually an agent of the Bureau. (The defendant claimed that the "patient" had said she was in great pain from a stomach ailment and that her regular physician was out of town; she claimed that she had said she as an addict). In a unanimous opinion, the Supreme Court reversed Dr. Linder's conviction, stating:

> The enactment under consideration ... says nothing of 'addicts' and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purpose solely because he has dispensed to one of them, in the ordinary course, and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction.

The Court also specifically held that the *Webb* and *Behrman* rulings should not be extended beyond the facts in those particular cases.[31]

The acceptance of medical discretion embodied in this decision has in no way been reflected in federal narcotics regulations:

> An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the act; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law.[32]

The *Linder* decision did not prevent the Bureau of Narcotics from carrying out what a recent account has termed a "persecution of the physicians"; at least during the period 1925-38 there were numerous prosecutions and convictions of physicians for narcotics violations.[33] There are probably few such cases today, partly because doctors have been so effectively cowed by the early prosecutions and stringent regulations.

The Bureau of Narcotics insists that it does not attempt to interfere with legitimate medical practice. Yet the physician's position remains tenuous. As a joint committee of the American Bar Association and the American Medical Association has noted, a physician's prescription of drugs for an addict will probably be upheld if it is in "good faith" and if he adheres to "proper medical standards." But these very questions can only be determined in the course of an actual court trial of a specific case:

> The physician has no way of knowing before he attempts to treat, and/or prescribe drugs to an addict, whether his activities will be condemned or condoned. He does not have any criteria or standards to guide him in dealing with drug addicts, since what constitutes bona fide medical practice and good faith depends upon the facts and circumstances of each case....[34]

Over the years the Harrison Act has been supplemented by many other antinarcotics statutes under which the aunauthorized possession, sale, or transfer of drugs is severely punished. Rather than constituting a rationally planned program for dealing with the narcotics problem, this legislation has mainly represented an emotional response to periodic crises. For example, public concern about narcotics--aroused by the Kefauver Committee's 1951 investigation of organized crime--resulted in a federal law (the Boggs Act) imposing severe mandatory minimum sentences for narcotics offenses.[35] Another congressional investigation four years later, focusing entirely on the drug traffic, led to the enactment of the Narcotic Control Act of 1956, which raised the minimum sentences for offenders and which permits the death penalty for those who sell narcotics to persons under eighteen.[36] In addition to the federal statutes, the various states have enacted their own antinarcotics laws.[37]

Many observers, including some prominent jurists, have condemned the harsh penalties imposed by recent drug laws--objecting particularly to the fact that such statutes typically draw no distinction between the nonaddict peddler and the addict. Illustrating these objections was the

1956 statement of Robert Meyner, former governor of New Jersey, vetoing a bill which would have increased mandatory minimum sentences for narcotics violators and barred suspended sentences and probation even for first offenders. Stating that he would have unhesitatingly approved if such penalties applied only to nonaddicted suppliers of drugs, Meyner noted:

> ...although the deterrent quality of punishment may be conceded in certain areas, the question remains whether deterrence may not also be achieved by severe sentences where the facts so warrant, without the inherent self-defeating weakness of laws which are excessively severe in cases involving individuals whose offenses do not merit the punishment commanded by the bills....[38]

The Failure of Enforcement

What have these legal policies accomplished? Law enforcement officials often assert that addiction is being kept under control, yet even government estimates have placed the number of addicts between 45,000 and 60,000, and almost all nongovernmental experts feel these figures greatly understate the problem. In any case, it is certain that these laws have not come anywhere close to eliminating addiction. They have, however, greatly influenced the narcotics problem. Cut off from legal supplies of narcotics, the addict naturally seeks illicit drug sources. The strong demand of addicts for their drugs means that there are huge profits to be made in the black market, and this in turn makes the risks involved in such an endeavor worthwhile. According to one account, the retail value of one thousand dollars worth of heroin may surpass three million dollars.[39] It is understandable, then, that the endless circle of supply and demand alluded to in the discussion of abortion should also be in evidence here. The addict's position in this exchange is so vulnerable that not only must he pay exorbitant amounts but typically he must settle for a highly diluted product; the repeated adulteration of narcotics as they go down the line from the original importer to the various distributors and ultimately to the addict is well-known. Many experts contend that no amount of law enforcement effort could reasonably be expected to stifle the black market in narcotics.

Such observers believe that, given the extreme and continuous demand of addicts, some way always will be found to make the drugs available illegally. For, as Robert Merton has suggested: "In strictly economic terms, there is no relevant difference between the provision of licit and of illicit goods and services."[40]

Most enforcement officials admit that the task of significantly curbing the smuggling of narcotics into the country is a pretty hopeless task. The former U.S. Commissioner of Narcotics himself has been quoted as saying that the combined efforts of the Army, the Navy, the Narcotics Bureau and the FBI could not eliminate drug smuggling. As a customs agent has pointed out, discussing his agency's operations in New York City:

> On normal passenger arrival days it is the policy of the collector of customs at the Port of New York to examine baggage 100 per cent, but when the passenger arrivals are heavy, a spot-check of baggage is performed. Under these circumstances it is not difficult to understand how a passenger using a false-bottom trunk or a suitcase with a false compartment might be able to conceal narcotics and get by the examining inspector; searches of persons are infrequently made and then only as a last resort and only based on substantial reasons.[41]

Again, as in the case of abortion, there occurs the competitive development of enforcement and antienforcement techniques.

But, basically, it is the supply-and-demand element and the lack of a complaining victim, rather than the cleverness of the law violators, that render the drug laws so largely unenforceable. Predictably in such a situation law enforcers must resort to special investigative techniques. A major source of evidence in narcotics cases is the addict-informer. Though the addict-informer faces grave danger of underworld reprisal, their eagerness to stay out of jail (and avoid sudden withdrawal from drugs) or simply their need for funds with which to purchase drugs impels many addicts to assume this role. The Bureau of Narcotics is authorized to pay the "operating expenses" of informants whose information leads to the seizure of drugs in illicit traffic; hence, the Bureau at least indirectly supports the addiction (and the "crime") of some addicts in order to uncover others. Despite this fact, and the questionable legal aspects involved in trapping suspects through informers, enforcement spokesmen insist on the propriety and even the necessity of such practices. According to two enforcement experts:

> The police officer who by methodical planning, supplemented sometimes by happy accident, is able to set up and maintain listening posts in the underworld, represents one of the finest professional developments in the unceasing war of organized society against underworld forces.[42]

Often the informer or even the narcotics agent himself will directly attempt to obtain a prescription or a supply of drugs from a suspected doctor or peddler or through an addict. Thus narcotics investigations frequently tread the fine line between detection and entrapment. As in the case of antihomosexuality operations, the courts will not uphold prosecutions based on acts or statements directly planned or instigated by enforcement officers. There is even the danger that enforcement activities may hinder attempts by addicts to curb their addiction:

> The case at bar illustrates an evil which the defense of entrapment is deisnged to overcome. The government informer entices someone attempting to avoid narcotics not only into carrying out an illegal sale but also into returning to the habit of use. Selecting the proper time, the informer then tells the government agent. The set-up is accepted by the agent without even a question as to the manner in which the informer encountered the seller. Thus the government plays on the weaknesses of an innocent party and beguiles him into committing crimes which he otherwise would not have attempted. Law enforcement does not require methods such as this.[43]

The use of informers and agent-decoys are not the only unpalatable police techniques used to combat the drug traffic. Perhaps more than any other category, narcotics cases have notoriously given rise to grave issues of constitutional law--as witnessed by major U.S. Supreme Court decisions dealing with alleged infringements of suspects' constitutional safeguards against improper arrest, illegal search and seizure, self-incrimination, and the like. One of the best-known of these decisions was in the case of Rochin v. California (1952). There the police, suspecting the defendant of dealing in narcotics, illegally broke into his room. During the course of a struggle with the intruding officers, the suspect managed to swallow two small objects which the officers had attempted to seize from a table near the suspect's bed. The police then rushed him to a hospital, where--despite his protests--a physician pumped his stomach. As a result, the investigators found morphine which was later used as evidence against him on a narcotics charge. The Supreme Court held unanimously that conviction on the basis of such evidence violated due process of law. Writing for the Court, Justice Frankfurter stated:

> ...the proceedings by which this conviction was obtained do more than offend some fastidious squeamishness or private sentimentalism about combatting crime too energetically. This is conduct that shocks the conscience. Illegally breaking into the privacy of the petitioner, the struggle to open his mouth and remove what was there, the forcible extraction of his stomach's contents--this course of proceeding by agents of government to obtain evidence is bound to offend even hardened sensibilities. They are methods too close to the rack and the screw to permit of constitutional differentiation.[44]

In addition to the questionable nature of enforcement activities, the efforts required to obtain evidence in narcotics cases may lead to an unwarranted expenditure of police energies (and hence, indirectly, of taxpayers' money). In one case five detectives spent a month in Greenwich Village disguised as "beatniks"; one was reported even to have achieved a slight reputation as a poet. According to a news account the entire New York police narcotics squad (then numbering 140 men and women) participated in resulting arrests.[45] If such efforts led to the conviction of leading figures in the drug traffic, they might be worthwhile. Yet it is widely known that current enforcement activities more often serve to ensnare minor violators. The American drug traffic involves at least four classes of sellers: importers, (rarely addicts themselves), professional wholesalers (also rarely addicts), peddlers (who may be addicted), and pushers (addicts who sell to get funds for their own drug supplies). As numerous commentators have noted, it is the addicts, pushers, and perhaps some peddlers who are most affected by antinarcotics enforcement. The Bureau of Narcotics and other government agencies protest that they have in fact managed to convict some of the major figures in the illegal drug traffic. But, as Judge John Murtagh has pointed out:

> The Bureau itself admits that there is a new dope ring to take the place of every one it smashes and that periodic round-ups, even if conducted on a national scale, while they may serve to weaken the racket never effect a killing blow. Perhaps the biggest round-up in American history was that staged in 1952... which netted a total of nearly five hundred suspects. But was the syndicate affected by this round-up? Hardly at all.[46]

In short, it is evident that the police face an impossible task in seeking to enforce current drug laws. The laws are inherently self-defeating. Even to approximate efficiency in their administration would require the wholesale violation of legal rights, which the courts will not permit. Likewise, judges are often unwilling to impose maximum sentences on addicted drug violators, and even prosecutors sometimes proceed against them under the less stringent of several possible charges. At the same time, enforcement personnel are under considerable pressure from segments of the public and from higher officials to produce results. It is not surprising, under these circumstances, that they exhibit strong hostility toward the addict, and view themselves as engaged in a "war" against addiction. With a sharp attitudinal dividing line separating the "good guys" (law enforcers) from the "bad guys" (those involved in the world of drugs), important distinctions such as that between the addict and the nonaddicted drug violator, blur or disappear.[47] These punitive attitudes, in turn, lead to increasingly brutal treatment of the addict, without any corresponding increase in the effectiveness of antinarcotics measures.

ADDICT CRIME AND SUBCULTURE

These laws do not merely fail to curb addiction, they also vitally influence addict behavior. The issue of crime by addicts has long concerned students of addiction. (The criminal behavior being considered here, of course, is not the mere possession and use of drugs--which may or may not be defined as criminal.) One point alluded to at the beginning of this chapter must be underscored here: there is no evidence suggesting that crime results from the direct effects of the drugs themselves. Also, the addict is much more likely to commit nonviolent crimes property than violent crimes against persons. This is to be expected from the depressant nature of the drugs. In an early study, psychiatrist Lawrence Kolb suggested even that "one is led to believe violent crime could be much less prevalent it all habitual criminals were addicts who could obtain sufficient morphine or heroin to keep themselves fully charged with one of these drugs at all times."[48] There is strong evidence that most crimes committed by addicts are undertaken in order to obtain funds with which to purchase illicit drugs. The statements and records of individual addicts amply corroborate the relationship between drug use and "crime for profit." Furthermore, the New York studies have shown that in high drug-use areas there are relatively high rates of cash-producing delinquencies (robbery, burglary, procuring, and the like) and relatively low rates of violent crimes and other nonprofit offenses.[49] Similarly, a study of arrest data for Chicago in 1951 (comparing cases handled in the Narcotic Bureau with those processed by the municipal police department) indicated that "the number of arrests for nonviolent property crimes was proportionately higher among addicts. In contrast, however, the number of arrests of addicts for violent offenses against the person, such as rape and aggravated assault, was only a fraction of the proportion constituted by such arrests among the population at large."[50]

A recurrent issue with respect to addict criminality has been whether addicts have criminal records antedating their addiction. Pescor, in a 1936-37 study of the records of over a thousand addict-patients admitted to the Lexington, Kentucky, U.S. Public Health Service

Hospital, found that a substantial majority were not antisocial prior to addiction.[51] In recent years, however, the Bureau of Narcotics has contended that most American addicts were involved in criminal activities prior to becoming addicted. Because drug use is concentrated in neighborhoods in which crime and delinquency also flourish, it is not surprising if there is some truth to this claim. But the most significant facts about addict-crime in the United States today seem to be that addiction reduces the inclination to engage in violent crime, and that persistent involvement in petty theft or prostitution (in order to support the drug habit) is an almost inevitable consequence of addiction. It is noteworthy that in Great Britain, where the addict usually can obtain needed drugs legally and at low cost, there is practically no crime associated with addiction. This is certainly in sharp contrast to the situation pointed up in the following statement by the Police Commissioner of New York City:

> The facts are that of our major crime arrests, about 7 per cent of the people arrested are addicts, users of drugs. We know many crimes are committed where no arrests are made, or an arrest is made after several crimes have been committed by the same person ... probably three times that 7 per cent -- 21 to 25 per cent of all crime results from the necessity to maintain the habit. This is particularly true in prostitution and petty larceny.[52]

Another apparent consequence of the illegality of narcotics is the expansion of, and immersion of most addicts in, a specialized addict subculture. Cohen's statement (see p. 85) of the conditions necessary for the emergence of a subculture included the effective interaction of a number of persons with similar problems of adjustment. In drug addiction, as in homosexuality, this condition is present. It has been argued that the addict benefits psychologically from knowledge of and contact with others who share his plight. Furthermore, certain forms of subculture which develop among addicts might exist even if drug use were not an important part of their lives. This reasoning is in line with the belief that a particular cultural climate underlies drug use and is also suggested by Harold Finestone's analysis of the "cool cat" pattern found among young male Negro addicts in Chicago.[53] Because all reports on known drug-users in the United States indicate that young male Negroes are highly overrepresented, this particular study may be of special importance.

The drug-users interviewed by Finestone varied, of course, but a dominant type emerged: these addicts had developed a way of life through which they could conceive of themselves as belonging to an elite group, a society of "cool cats." The "cat" tended to be a sharp dresser, a smooth talker, and a clever manipulator--someone who could stay "cool" in the face of difficulties. He viewed himself as an operator, and in general held "squares" in contempt. His relations with women tended to be exploitative, sometimes leading the "cat" into pimping or at least into admiration of the pimp role. The "cat" prided himself on getting by without working, and each "cat" had some "hustle"--a nonwork way of "making some bread" (obtaining money. Every cat also had his "kick"--and the appeal of heroin was that it provided the ultimate kick. In short,

> The "cat" seeks through a harmonious combination of charm, ingratiating speech, dress, music, the proper dedication to his "kick," and unrestrained generosity to make of his day-to-day life a gracious work of art. Everything is to be pleasant and everything he does and values is to contribute to a cultivated aesthetic approach to living. The "cool cat" exemplifies all of these elements in proper balance. He demonstrates his ability to "play it cool" in his unruffled manner of dealing with outsiders such as the police, and in the self-assurance with which he confronts emergencies in the society of "cats." Moreover, the "cat" feels himself to be any man's equal. He is convinced that he can go anywhere and mingle easily with anyone...[54]

Finestone's interpretation of the factors underlying this pattern highlights elements that would pertain even in the absence of addiction, and in fact he states that the basic features of the "cats' " orientation very likely preceded their introduction to heroin. He suggests that "the 'cat' as a social type is the personal counterpart of an expressive social movement," and states that this phenomenon must be viewed in the broader context of the social segregation and discrimination experienced by these Negro youths. The "cat" may represent one type of adaptation to the various frustrations felt by this group, one attempt to develop a separate social system in which security and status can be achieved--while repudiating the norms and values of the discriminators (the larger society). Finestone also notes that some features of this way of life (such as concern with dress, music, language, and pleasure-seeking) are characteristic of the adolescent world generally. But in addition to the typical problems of adolescence, the "cat" is "confronted by a special set of problems of color, tradition, and identity."

Repression Breeds Subculture

Addict subculture also reflects the pressures produced by anti-addiction policies. That is brought out in an analysis of addict life prepared by Seymour Fiddle, a sociologist working with the East Harlem Protestant Parish in New York:

> While certain patterns of addict life may have been in existence before the Harrison Act, the conversion of addiction into a mass criminal activity appears to have given special form and meaning to addiction, so that we may speak reasonably about an addict culture operating as a system.[55]

Fiddle cites the existence of two major aspects of this subculture: the "circulatory system" and the "survival system." The former term refers to the system of roles and interrelationships through which addicts secure illegal drugs. With the exception of physician-addicts and some other well-to-do addicts who may obtain narcotics (illegally, but with slight risk) from "legitimate" sources (such as doctors and pharmacists), all addicts in the United States must enter into the complex underworld network distributing illicit drugs. The addict, then, is of necessity thrown into contact with drug peddlers or pushers, he may very likely become a pusher himself in order to support his habit, he invariably comes to engage in frequent interaction with other drug-users as well as with distributors. It is to his practical as well as psychological advantage to engage himself in every aspect of the drug-distributing and drug-consuming world. Fiddle makes this clear in discussing key features and functions of the "survival system," which he lists as follows: (1) ideology of justification; (2) the "reproductive" process; (3) defensive communication; (4) neighborhood warning systems; (5) ritualistic, magical and cyclical patterns; and (6) the attractiveness of personal relations.[56]

Like other oppressed minorities, drug addicts adopt a justifying ideology to support their morale and lessen their feeling of isolation. Although this might be true even in the absence of legal repression, it is all the more important in the face of such repression. By "reproductive" process, Fiddle refers to the fact that the system continually requires new members in order to maintain itself. The considerable involvement of addicts in the drug-distribution process has led some observers to assert that it is basically the addicts themselves who spread the habit, and that therefore elimination of the "professional" peddler would not appreciably alter the problem of addiction. In this view, the subculture and the addict-pusher are seen almost as causes of the addiction problem. Yet the evidence indicates that they are at least partly caused, in turn, by the supply-demand cycle and the pattern of legal repression. In any case, it is obvious that behind whatever distribution addicts themselves engage in are professional illicit suppliers who are motivated solely by the desire for profit. As one addict has put it: "The trail always leads back to the same direction, to the peddler who was originally around to turn somebody on [introduce him to drug-taking]....[57]

Addict argot and special speech and gestural habits may serve practical as well as morale-enhancing functions. The need for cohesive ties in the face of strong adverse reaction is especially conducive to the development of such argot among deviants. But defensive communication means more than just a special addict jargon. Another aspect is the "grapevine system":

> Information about the coming of the police, or about the kind of heroin being sold, in different parts of the city, are said to pass rapidly and accurately, with what is said to be greater safety than that furnished by the telephone....Information is sifted out according to a consensus concerning the reliability of different individuals. In particular, there is a belief that informers can be spotted so that they can be excluded from the grapevine or sent onto a fake grapevine. In some periods, information can be so valuable that it is paid for by the addicted.[58]

It is also reported that in some neighborhoods (particularly where there is an ethnic or other communal bond) even nonaddicts may be more or less willing to protect addicts from police interference. Despite the usually strained relations between addicts and their nonaddicted neighbors, "a residue of loyalty may continue to keep the local populace from any active cooperation with the police." As part of the "ritual, magical, and cyclical patterns" Fiddle discusses the addict's use of time--which reflects the bondage of addiction and the need for addicts in our society to devote almost all their energy to the search for illicit supplies:

> There is a time, or some time, for getting money; a time, or some time, for getting drugs; a time, or some time, for using the drugs. (An interesting point is the way in which the term *scoring* [purchasing] has been inflated to cover all phases of the process.) This triadic pattern may be repeated several times a day, or may be abbreviated according to the skill and fortunes of the addicted person. But whatever the combination, the day is ordered according to a detectable perspective.
>
> Through police intervention this perspective may well lose its clarity, so that the day is increasingly freighted with despair, bitterness, and confusion. These experiences themselves act as secondary sources for drug use as the drug is called upon to perform sedative functions...[59]

Finally Fiddle notes that addict "life" serves a general function (presumably more psychological than practical or defensive) in fostering intense interpersonal relationships between addicted individuals.

It should not be thought that the addict subculture engulfs everyone coming into contact with it. In all high drug-use neighborhoods nonusing "squares" live alongside the addicts. Although drug distribution is closely related to the underworld, delinquent gangs as such are not a key factor in the promotion of addiction. In New York it was found that although some gangs provided "an arena in which the use of narcotics can develop," generally the gangs not only discouraged and inhibited drug use but also satisfied needs "which may otherwise lead to earlier use...."[60] Another type of misapprehension about the addict subculture may be inadvertently created by "inside" accounts of addict life in America. It is not true that addiction to narcotics automatically makes the individual a member of an addict subculture. This is shown, for example, by one study of American physician-addicts. Those interviewed "almost never associated with other physician-addicts, or did not do so knowingly. They did not have any occasion for doing so, either for the purpose of getting drugs or for passing time, or for emotional support."[61] As might be expected, it was similarly found that the physicians in question did not make use of the special addict jargon. Thus, although there may be some psychological pressures working to bring addicts together, the addict's over-all social and legal status and his relation to drug sources seem to be the overriding factors determining subcultural membership. This point is borne out by the experience in Britain, where the availability of drugs eliminates the need for addicts to involve themselves in underworld distribution processes and thus prevents the significant development of an addict subculture.

The gradual immersion of most American addicts in a world of their own is inextricably connected with the general process by which they have been cast out of respectable society. The social definition of the addict as a criminal not only vitally influences his behavior but also significantly affects his self-image. Certainly the knowledge that one has become fully addicted must in itself have a profound impact on this self-image. At the same time it is noteworthy that although the physician-addict and the subculture-type addict are addicted in precisely the same physiological sense, their self-images are likely to be strikingly different. Both may recognize themselves as addicts, yet the physician is most unlikely to consider himself a criminal. On the other hand, the addict who is driven to underworld connections and to crime in order to support his habit cannot help but begin to feel that he is an enemy of society (or at least that society is his enemy). A self-fulfilling-prophecy cycle is set in motion from which it is very difficult for such an addict to extricate himself. He is aware that respectable people view him as a criminal, and he sees that he is beginning to act like one.[62] Increasingly he must turn to the drug world for interpersonal support as well as for drug supplies. As the need to finance his habit occupies more and more of his time and energy, and as other worlds (such as those of work, family, and so on) recede into the background or fade away completely, addiction becomes a way of life.

TREATMENT

Attempts to deal with this extremely complex situation have mainly involved the medical and psychiatric treatment of individual addicts. It is not difficult, in a hospital setting and perhaps elsewhere, gradually to withdraw the addict from drugs with a minimum of discomfort. Unfortunately this does not constitute a real cure, for the key characteristic of the confirmed addict is the craving for the drug which exists even when there is no physical dependence. Experts are agreed that various types of postwithdrawal assistance will usually be necessary if any real success is to be achieved.

Until recently most of the treatment of addicts in this country took place in the U. S. Public Health Service hospitals at Lexington, Kentucky, and at Forth Worth, Texas. With highly qualified staffs and a comprehensive treatment program--including gradual withdrawal from drugs, vocational and recreational activity, and a limited amount of psychotherapy--these treatment centers have represented a well-intentioned effort to deal with the addict medically. However, most nongovernmental observers feel that the results have been far from satisfactory. To begin with, the federal hospitals, which accept both voluntary patients and some compulsory committals of addicted drug law violators, have a combined capacity of less than 2500. Recognition that such facilities are totally inadequate has led, in the last five years or so, to the establishment by several states and large cities of either special institutions or special units in general hospitals. It seems likely that more and better treatment facilities will become available in the near future.

But increasing the number and improving the quality of such facilities does not strike at the heart of the problem of treating addicts. Any treatment effort must come to grips with the disheartening phenomenon of probable relapse. Favorable estimates have placed the rate (for the major specialized-treatment institutions) at around 75 per cent; less optimistic estimates, at 90-95 per cent.[63] Such statistics reflect something more basic than the shortcomings of particular institutions; they illustrate the impossibility of overturning, by conventional procedures, what is often a way of life. On his return to the community, the treated addict faces many of the same sorts of difficulties experienced by the former convict: lack of understanding among relatives and non-addict friends, inability to obtain a decent job, reinvolvement in the very cultural climate and interpersonal associations which may have led him into the deviance in the first place. These are all very real problems associated with relapse, and a comprehensive treatment program must seek to cope with them. But, in a broader sense, a complete reassessment of the individual's outlook on life and his view of his own goals and behavior may be necessary. It has been suggested that, after successful withdrawal, the former addict begins a running struggle with his problem of social identity. As the same writer goes on to state:

> The ex-addict who is successful in remaining abstinent relates to new groups of people, participates in their experience, and to some extent begins to evaluate the conduct of his former associates (and perhaps hiw own when he was an addict) in terms of the values of the new group.[64]

Even prolonged individual psychotherapy may be insufficient to produce this kind of transformation.

A Community Program

A comprehensive program of action-research in the voluntary treatment of male addicts at New York City's Metropolitan Hospital has convinced psychiatrists involved in that project that "new types of therapeutic intervention" are needed, "and, above all, a public health approach with the emphasis on prevention of the disease." Experience there has indicated that the goals and orientations of standard psychotherapy tend to clash with the addict-patient's preoccupation with short-term situational problems; that the differences between the socioeconomic backgrounds and life experiences of therapist and those of the addict cause "serious communication and countertransference problems"; and that even medically trained therapists may exhibit considerable ambivalence regarding the program's objectives and techniques as well as in their general attitudes toward addicts and addiction.[65] The modest success of the program at Metropolitan Hospital has been largely the result of the attempt to relate treatment efforts to the addict's total situation in the local community -- particularly through the development of a close working relationship with a neighborhood agency long occupied in assisting addicts. Out of this relationship have come regular referral of patients (all voluntary), continuous sharing of information about the drug situation, and a program under which psychiatrists from the treatment unit actually spend time at the agency seeing former and prospective patients and increasing their awareness of the addict subculture. The clergyman-director of this agency insists that "neighborhood-based referral and aftercare units are the most important of a number of parts in a total treatment program for the addicted." [66] Treatment-researchers at Metropolitan have outlined a "model continuum" for a total community-based addiction-treatment program. After the initial contact between the addict and the medical staff -- which might occur at the hospital or in a cooperating neighborhood agency -- there would be a period of ambulatory care "until there could be an effective referral to the in-patient facility for detoxification." Such out-patient care could take various forms: "The patient may enter a sheltered workshop program, may be placed on a pharmacological regime, or may be engaged in a form of interview treatment. . . ." Once the withdrawal from drugs has been accomplished, the patient would be admitted to a Day-Night Center, located away from but near the hospital. After an extended stay there, he would "return in gradual stages to his neighborhood under the continued supervision of a clinic which would be jointly operated by the hospital and the neighborhood agency." The patient would continue to receive varying forms of help from the treatment team "until rehabilitation and social integration were achieved."[67]

Such a program does not directly solve the problem of establishing socially constructive neighborhood values and institutions into which the treated addict can be "integrated," but it does represent an effort to relate individual care to the neighborhood setting. A similar, if more modest, attempt to link institutional therapy with readjustment to the community is seen in the establishment of "halfway houses" in which addicts released from treatment institutions can reside prior to complete reinvolvement in the community at large. Because under current laws the institutionalization many addicts undergo is in prisons or prison-like treatment centers, this scheme may have special value. Gradual introduction to outside life, group and individual counselling, vocational guidance, and general support may be provided in such a setting. On the other hand, compulsory assignment to such a program, especially when the program maintains direct links with the formal administration of correctional institutions, may partly undermine its effectiveness.[68]

Synanon House

A more direct attack on the addict's probable commitment to a deviant value system and way of life has been the program of Synanon House. Under this program former addicts live with and work with current ones -- withdrawing them from drugs and attempting gradually to win them over (through group discussions and other techniques) to antidrug attitudes and positive social goals. Although available statistics are meager, it does appear that Synanon has been effective in keeping a substantial number of former addicts off drugs for prolonged periods. In analyzing the program's relative success observers have pointed to the insistence that each member voluntarily submit to the rules of an expressly antiaddiction group, the continuous indoctrination by the group in new attitudes and behavior patterns, the group cohesion which develops through common purpose and which is enhanced by the fact that the "reformers" are of the members' "own kind," and the program's system of work roles representing "stages of graded competence" in which the member works his way up to levels of increased responsibility and obtains a status quite different from that of mere inmate or even patient.[69]

One of the shortcomings of the program has been that, despite the plan that members should eventually work their way out of the system so that they are both living and working in the outside community, most members who have successfully abstained from drugs have in fact remained (vocationally as well as residentially) within the organization. This suggests limits on the extent to which Synanon can fully rehabilitate addicts (let alone solve the addiction problem). One writer, emphasizing these limitations, has suggested that actually members have substituted a dependence on Synanon for the dependence on drugs, and that the program should be seen as a protective community rather than a truly therapeutic community aimed at the eventual reintegration of the patient with the outside world.[70] Despite this shortcoming, Synanon seems to show considerable promise as a device for the voluntary treatment of at least some addicts. The program has encountered community protests in various locales when it has attempted to set up residential centers, but this has not prevented the establishment and apparently smooth operation of a number of Synanon houses.

Key Treatment Issues

Most general discussions of the treatment of addiction have indicated dispute about three central and interrelated issues. The first involves institutional versus out-patient treatment. Experts generally agree that a hospital provides the most appropriate setting for the withdrawal of the addict from drugs. At the same time, some observers emphasize that specialized treatment facilities for addicts have certain drawbacks. One authority states: "My opinion, borne out by experience, is that any treatment center which brings active drug addicts together in large numbers is bound to fail of its purpose."[71] One addict's account of her stay in Lexington emphasized the fact that conversation among the patients was almost entirely about narcotics. Rather than being weaned away from the world of drugs, the patient may thus experience a strengthening and reinforcement of his identification with that world. As this girl went on to say, it was on release from Lexington that she became convinced she was an incurable addict: "I felt beaten when I got out of there, really beaten."[72] The very process of treatment, then, if it occurs in a compulsory context, may promote and reinforce the addict's deviant self-image.

Officially, American policy has sanctioned only institutional treatment of addicts. Out-patient treatment has persistently been repudiated in material distributed by the Bureau of Narcotics -- which frequently cites a 1924 pronouncement of the American Medical Association opposing such treatment. Insistence on the need to hospitalize addicts may prevent useful exploration of other treatment approaches. One project in New York has indicated that some addicts can be successfully withdrawn on an out-patient basis, and suggested that the difficulties of dealing with addicts as voluntary out-patients have sometimes been exaggerated. The ability of this project to keep thirteen addicts in voluntary out-patient treatment for a full year was attributed to its nonpunitive and nonmoralizing orientation .[73]

Closely related to the out-patient-institutional dispute are strong differences of opinion about the value of compulsory treatment. Under present policies, most institutionalization of addicts is more or less compulsory. Addicts are directly committed by courts, given the option of commitment instead of prison, or else forced into treatment by the pressures of maintaining the drug habit illegally (for example, many addicts undergo withdrawal treatment in order that they can resume their drug use at a lower dosage level and hence at lower cost). The extremely high relapse rate has convinced some observers that compulsory treatment simply will not work. When the compulsion is blatant, it will make little difference that the institution is called a treatment center or hospital, and that the addict is labeled a patient rather than an offender. As Szasz and Goffman have suggested in their discussions of commitment to mental institutions, the facts of deprivation of liberty and of involuntary immersion in the life of a "total institution" will often overshadow in the committed individual's view any appreciation he might have of efforts by the treatment staff to help him.[74] This may be particularly true in the addict's case since ordinarily he will be fully capable of understanding just what is happening to him. In any case, apart from how the patient views a specific institutional program, there is the basic problem that without the addict's cooperation in a genuine effort at prolonged abstinence no cure can be expected. Although some therapists have stated that addict-patients require compulsion to help them develop the self-discipline necessary for a cure, others stress that the success of any treatment program has been the result of its voluntary character. They urge that it may be necessary to recognize that one simply cannot cure an addict, in the long term, against his will.

This brings up a third major issue in addiction treatment: are the terms *cure* and *treatment* synonymous? All specialists agree that addiction is undesirable and that the ultimate goal should be its elimination -- insofar as that is possible. Some believe, however, that a preoccupation with the total elimination of addiction and with the cure of individual addicts has unnecessarily limited efforts at more general medical management of the addiction problem. Thus it has been widely argued that any treatment program under which some addicts might receive medically prescribed drugs would involve doctors in the perpetuation of disease and amount to an abandonment of the effort to cure addiction. This argument conveniently ignores the fact that addiction is actually being perpetuated under the present arrangements, even if doctors play no direct part in its perpetuation. As the author of the New York Academy of Medicine's 1955 proposal for narcotics clinics pointed out:

> We are not saying to give the addicts more drugs. We are simply advising a different method of distribution. . . every addict gets his drug right away . . . why not let him have his minimum requirements under licensed medical supervision, rather than force him to get it by criminal activities, through criminal channels?[75]

Increasingly, proposals for narcotics reform urge placing as many addicts as possible under some kind of medical management. Treatment should depend on the particular addict's problems and prognosis. If medical administration of drugs is necessary even for a prolonged period --

during efforts to enlist cooperation in a cure, or in a case in which cure seems unlikely -- then such administration (occurring as past of an over-all treatment program) should be considered a legitimate aspect of medical practice in this area. These proposals involve recognizing that different types of addicts may require varying treatment approaches. Even more significantly, perhaps, they offer a major advantage conspicuously absent from all crash programs to cure individual addicts. Medical administration of low-cost legal drugs could drastically undercut the economic incentives underlying the illicit traffic and could largely eliminate various secondary aspects of addiction as a social problem.

THE BRITISH EXPERIENCE

Realization of this possibility has heightened American interest in Great Britain's approach to the narcotics problem.[76] In sharp contrast with American drug policies, the British procedure is to treat addiction almost entirely as a medical matter. The general tenor of public policy was suggested in the 1926 report of a governmental advisory committee: "With few exceptions, addiction to morphine and heroin should be regarded as a manifestation of a morbid state, and not as a mere form of vicious indulgence."[77] Under the Dangerous Drugs Act[78] and supplementary regulations, the British maintain careful control over the possession and supply of opiates (and certain other drugs). Authorized drug-handlers must keep full records of all drug transactions, and such records are subject to periodic inspection by the Home Office and special Ministry of Health inspectors. Doctors who improperly divert narcotics supplies to their own use or who otherwise violate the drug laws are subject to fine or imprisonment, and also may lose the right to possess and prescribe such drugs. The treatment of addicts, however, rests with medical practitioners. Although the government advises doctors to exercise caution in prescribing narcotics, physicians may in fact legally supply narcotics to addicts:

> . . . morphine or heroin may properly be administered to addicts in the following circumstances, namely (a) where patients are under treatment by the gradual withdrawal method with a view to cure, (b) where it has been demonstrated, after a prolonged attempt at cure, that the use of the drug cannot be safely discontinued entirely, on account of the severity of the withdrawal symptoms produced, (c) where it has been similarly demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued.[79]

A Home Office memorandum to doctors warns that "the continued supply of drugs . . . solely for the gratification of addiction is not regarded as a medical need,"[80] but the physician remains the final arbiter of what constitutes proper medical treatment of addicts. There have been only a few cases in which physicians had been prosecuted for what was thought to be overprescribing to addicts; when there is such a prosecution, the courts tend to uphold the physician's professional judgment. Inspection of drug records is used mainly to uncover doctor-addicts who may prescribe for fictitious patients. Even when such instances come to light, the doctor is likely to receive a relatively light punishment -- typically a fine and withdrawal of his authority to possess and prescribe dangerous drugs.

There is no required registration of addicts in Britain, but doctors are requested to inform the Home Office of addicts coming to their attention and it is believed that the Office's file contains brief data on most of the country's addicted persons. The British make no provision for compulsory commitment of addicts, but most doctors apparently do try gradually to reduce the addict's dosage and to induce him to undergo institutional withdrawal treatment. An authoritative American report has summarized the British policy as follows:

> . . . The British medical profession is in full and virtually unchallenged control of the distribution of drugs, and this includes distribution, by prescription or administration, to addicts when necessary. The function of the police is to aid and protect medical control, rather than to substitute for it.[81]

In 1961, a British government study found this policy to be working well. Changes disapproved by an Interdepartmental Committee included compulsory committal, compulsory registration of addicts, and the establishment of specialized-treatment institutions. It stated also that "irregularities in prescribing of dangerous drugs are infrequent and would not justify further statutory controls."[82]

Under this policy the British addiction problem has remained remarkably benign.[83] There are believed to be less than one thousand opiate addicts in the entire United Kingdom. There is practically no illicit traffic in opiates, because the legal provision of low-cost drugs (the addict qualifies as a patient under the National Health Service and is charged only two shillings per prescription) has largely eliminated the profit incentives supporting such traffic. Similarly, as already noted, serious addict-crime is almost nonexistent. The addict in Britain need not become a thief or a prostitute in order to support his habit. Very few addicts are imprisoned for any sort of offense. Occasionally an addict will commit a minor violation of the narcotics laws (for example, forging a prescription) to increase his legally prescribed dose, but such incidents are not frequent. Addiction and the underworld have not become intermeshed, and there has been no serious spread of narcotic addiction to juveniles. British policy has also inhibited the development of an addict subculture. The addict is not subjected to a continuous struggle for economic survival and for drug supplies, nor need he constantly attempt to maximize his anonymity and mobility. There is relatively little need for group support, and actual contact with other addicts may be slight. Despite the lack of compulsory commitment and special treatment, there is no evidence that the British have been any less successful in treating addiction as a disease than we have in this country. It is, in fact, quite possible that a nonpunitive approach, such as the British have taken, increases the likelihood of enlisting the cooperation of addicts in serious attempts at cure.[84]

There have been conflicting interpretations of the British experience. The Federal Bureau of Narcotics has sought to convey the impression that British policy is really the same as that in this country -- noting that in Britain narcotics are subject to wide statutory control and that indiscriminate administration of drugs to addicts is not permitted. Attention is focused on the warning against prescribing "for the mere gratification of addiction," while the stated (even if nonstatutory) criteria for prescribing, as well as the general spirit of British policy and its actual administration, are largely ignored.[85] More serious arguments concern the significance of Great Britain's successful control of addiction and its relevance to the drug problem in this country. Some observers believe that the British have been able to adopt a nonpunitive policy precisely because of the benign nature and extent of their addiction problem. Likewise it has been suggested that the vastly differing drug situations in the two countries, as well as more general cultural differences, render the British experience largely irrelevant to the American situation.[86]

On the other hand, there is no denying that the British have kept addiction under remarkable control, and it would seem that their refusal to treat the addict as a criminal has at least helped to keep him from becoming one. The differences between the two countries and their addiction problems do not, in themselves, invalidate elements of medical and sociolegal soundness embodies in the British policies. Clearly, Great Britain has developed no secret formula that would solve the addiction problem in the United States. And it is possible that disputes about the British system have even confused the discussion of proposals for changing American policy. Proponents of a reform cite the British approach with approval -- not as a universally applicable panacea, but as an illustration of the common sense and humanity felt to be lacking in American policies, and as evidence that a medically oriented approach to addiction need not have disastrous effects.

STEPS TOWARD REFORM

For some years it has been evident that the American medical profession does not entirely support prevailing antinarcotics measures. One of the first major statements by an important medical organization was made in 1955 by a committee of the New York Academy of Medicine:

> There should be a change in attitude toward the addict. He is a sick person, not a criminal. That he may commit criminal acts to maintain his drug supply is recognized; but it is unjust to consider him criminal simply because he uses narcotic drugs. The Academy believes that the most effective way to eradicate drug addiction is to take the profit out of the illicit drug traffic.[87]

To that end, the committee proposed a national network of federally controlled dispensary-clinics at which addicts could receive drugs at low cost. The clinics, it was felt, would provide a setting for intensive treatment efforts and research. In a second report, issued in 1963, the Academy reviewed the controversy caused by its original proposals, evaluated findings and arguments concerning the British experience (from which the committee found "nothing that alters and much that supports its conception of what ought to be done in the United States"), and strongly reaffirmed its earlier call for a medical approach to addiction. The committee emphasized that present policy does nothing to curb illicit traffic by removing profit incentives, and unnecessarily hampers doctors in their treatment of addicts. The report concluded with an insistence that the addict be considered a sick person: "This attitude should be a dominant thesis permeating and setting the tone in the policy and practices of every agency."[88]

Also very influential has been the report of a joint committee of the American Bar Association and the American Medical Association -- originally issued in 1956 and published for general distribution in 1961.[89] A comprehensive analysis of the entire drug problem, this report recommended the establishment, on a controlled basis, of an experimental out-patient clinic for the treatment of addicts, in order to explore the possibilities of treatment in the community as well as in institutions. Other medical groups and prominent individuals have urged reforms which would include experimentation with out-patient treatment and even maintenance of drugs. The official position of the AMA on these matters now seems to be that although it does not approve of either procedure, limited experimentation on these matters by qualified practitioners is consistent with good medical practice.[90] Such experiments are beginning to be undertaken. The National Association for the Prevention of Addiction to Narcotics (NAPAN) has announced two pilot programs that will test ambulatory treatment,[91] and the New York State Department of Mental Hygiene has begun a small-scale experiment to test the consequences of providing addicts with controlled doses of drugs.[92] The results of these preliminary tests will have to be assessed cautiously. Because different types of addicts may require or be amenable to different forms of treatment, no single path for the future treatment of addiction is likely to be indicated. On the other hand, if the subjects in these experiments have been carefully chosen, and if excessive generalization from the findings is avoided, some new light may be thrown on the diversity of possible treatment approaches.

Such experimentation may be expected to continue for some time, but recent and pending legislation and pronouncements at the 1962 White House Conference on Narcotics and Drug Abuse[93] indicate that the major innovation policy in the near future will be the "civil commitment" approach. Under this plan (variants of which have been adopted in New York and California), some addicted narcotics offenders are given the option of undergoing treatment while criminal charges are held in abeyance. Although these plans do envision some possibilities for voluntary commitments, it appears that they will typically operate after arrest -- merely providing an alternative disposition of the offender. The program may afford certain addicts a little better treatment than they would have received under previous laws, but the total punitive context would not be significantly altered. As Lindesmith has stated:

> The system's faults appear to be limited applicability, reliance on coercion, failure to make any fundamental change in the structure of the criminal law and failure to give the medical profession an important role. The plan will probably not materially affect the illicit traffic, the criminality of addicts or the spread of the habit.[94]

Such a program seems unlikely to meet with much success, for it relies on a form of compulsory treatment. Though some proponents of civil commitment have given the impression that it represents a real breakthrough towards a medical policy on addiction, critics state that it is a weak compromise reflecting at best an ambivalence in the attitude toward the addict.

This ambivalence was seen in the recent report of the President's

Advisory Commission on Narcotics and Drug Abuse.[95] The Commission recognized that harsh legal sanctions will not by themselves solve the narcotics problem and called for increased emphasis on rehabilitation. It proposed amendment of existing laws with their mandatory minimum sentences to allow for more judicial discretion, particularly in cases involving possession of drugs without intent to sell. Although it recommended new treatment programs and more assistance to treatment efforts, the Commission strongly supported the civil commitment idea, and in fact called specifically for a federal civil commitment law. Although the Commission rather abruptly dismissed the British experience and stated the dominant view opposing out-patient treatment and the sustaining of repeatedly relapsing addicts on maintenance doses, it did approve experimentation in these areas, and also called for amendment of the existing federal regulations on medical treatment of addicts. The Commission also proposed some organizational changes which could have the effect of more strictly limiting the Bureau of Narcotics' activities to law enforcement matters.

ARGUMENTS AGAINST LEGALIZATION

Although there is a growing receptiveness in the United States to the redefinition of drug addiction as a medical problem, strong opposition continues to be directed against any plan that can be construed as involving legalization of addiction. One of the key arguments has already been noted -- that any legal provision of drugs to addicts constitutes an abandonment of the fight to eradicate addiction. A second line of opposition asserts that legalization would not produce the desired beneficial results. Addicts, it is claimed, would not be content with the legally provided drugs, and illicit traffic and addict-crime would persist.

In this connection, federal drug officials frequently cite the early and largely unsuccessful experiment with municipal drug clinics. Between 1912 and 1925 there were clinics dispensing low-cost narcotics to addicts in over forty American cities. These institutions operated for varying lengths of time and with varying degrees of efficiency and success; eventually they were all closed down by the federal government. There is considerable dispute about this clinic program. Some accounts indicate that in certain localities legal provision of low-cost drugs by the clinics cut significantly into the black market as well as putting large numbers of addicts into contact with medical men. It appears that the clinics were shut down largely on the basis of complaints against the one in New York, which was so badly mismanaged that its activities hardly provided a reasonable basis for any general evaluation of a clinic program.[96] However, it is clear that medical men were disillusioned about the operation of clinics, and in 1924 the American Medical Association passed a resolution calling on federal and state governments "to exert their full powers and authority to put an end to all manner of so-called (i.e., out-patient) ambulatory methods of treatment of narcotic drug addiction , whether practiced by the private physician or by the so-called 'narcotic clinic' or dispensary." At least until very recently this resolution has been cited by the Federal Bureau of Narcotics as constituting the final and unchallenged stand of the medical profession, and as support for the Bureau's opposition to a full medical addiction policy.[97]

It is evident that the clinic experiment was not a striking success, but few impartial experts infer from it the inevitable failure of any such program. A key question, of course, is whether the addict's increasing tolerance will always cause him to seek more and more drugs, and hence to be unsatisfied with legal supplies. There is considerable argument about this point, and (as noted) some experiments designed to discover the answer are now being conducted. It is known that at least some addicts have been able to get along fairly well on relatively stable doses, and the British experience seems to lend further support to this possibility.

It is sometimes argued that medical management of addiction would actually make the situation much worse -- in particular, that it would lead to a vast increase in addiction. In suggesting this, opponents of reform have been less than scrupulous in their characterization of reform proposals. They have, for example, described plans for a medical approach as involving "giving everyone free access to drugs." Such characterizations ignore the general treatment context within which any proposed prescription of drugs would occur, as well as the fact that all such plans limit the program to existing addicts. Furthermore, as the New York Academy of Medicine has pointed out, even in those relatively few instances where (after careful clinical evaluation) maintenance is deemed necessary, the cases would be kept under continuous review. Most of these patients would be maintained "only until it was determined that withdrawal was appropriate and they were ready for it. For many the period would be short."[98]

It is true that legal administration of drugs to known addicts would not directly produce any decrease in the number of addiction cases, but that would not be the immediate purpose of such a program. On the other hand, as a careful analysis of the various arguments recently noted: "There is not the slightest reason to suppose that the new policy would increase the number of addicts. If anything, it would tend to inhibit the induction of new cases."[99] This is because, as has already been seen, significant effects on the illicit traffic could be expected.

At the core of much of the officially expressed opposition to drug-law reform has been the conviction that addiction is a vice which should not in any way be condoned and that the addict is basically a wrongdoer and not just a sick person. The Federal Bureau of Narcotics has ignored the fact that addiction is no more condoned by being managed medically than it is by being fostered illegally. It has refused to recognize the element of compulsion underlying the addict's behavior, and the fact that legal pressures account for much of his criminal activity. Representative of this viewpoint is the assertion by former U. S. Commissioner of Narcotics Harry Anslinger that almost all addicts are parasites and that "the paracitic drug addict is a tremendous burden on the community."[100] During his tenure of office, critics stressed the influence of Anslinger's views and activities, often calling for his retirement (which took place in 1962) as a key prerequisite to reform.[101]

PUBLIC ATTITUDES TOWARD ADDICTS

Opponents of reform have insisted that public opinion would never countenance a radical change in narcotics policy. According to one law enforcement officer, addiction is similar to robbery in that "both of these types of behavior, even though they were not illegal, would still be offensive to the great majority of the public, which would react by lynch law or some other type of punitive activity."[102] Actually, statements of this sort represent mere assumptions as to how allegedly right-thinking people should or will feel. There are not many data directly bearing on public attitudes toward addicts and addiction. Although a few studies have revealed strongly punitive outlooks on narcotics use, it is likely that these views are now being tempered by the new emphasis on medical approaches. As the public gets more accurate information about addiction, it is more likely to distinguish in its judgments between the addict and the nonaddicted distributor. It has been pointed out, too, that such punitiveness as does exist has been largely the result of the long-time dissemination of antiaddict views by narcotics officials. Public opinion cannot be presented as the basis or justification for a punitive policy when it has -- at least in part -- been created by that policy.[103]

Various factors may account for the wide public acceptance of punitive attitudes on addiction. Like the homosexual, the addict has long served as a scapegoat:

> Addicts, to a greater or lesser extent, always have been a pariah class which has not been in a position to refute any charges levelled against it. Apparently it gives people some kind of secret satisfaction to call names when they cannot understand.[104]

Some of the hostility toward addicts has undoubtedly been due to the misconceptions fostered by the "dope fiend" myth. But even among individuals who reject the myth there may be little sympathy for the addict. The very passivity and unproductiveness characteristic of most addicts are strongly disapproved of in the dynamic, work-oriented American society. The fact that some addicts would work reasonably well when receiving legally prescribed doses might not greatly influence the general reaction, even if it were more widely known. That the acceptance of certain relatively unproductive individuals might be less socially undesirable than the forcing of such individuals into overtly antisocial acts is a viewpoint that has yet to receive wide approval.

Until recently, the addict had few public spokesmen while the repressive, antiaddict attitude received strong support from public officials. Indeed, some critics argued that these officials had developed a vested interest in existing policies. In a sense, the medical profession also benefited from such policies, which relieved the profession of the responsibility for dealing with addiction. Inability to effect easy and lasting cures, and the well-known fact that addicts are extremely difficult patients, may have contributed to medical ambivalence toward drug-law reform. One of the major factors behind such policy changes as are now taking place is the medical profession's apparent willingness to accept increased responsibility for the treatment and management of addicts. Although this change of heart may reflect an acceptance of some of the sociolegal considerations outlined in this chapter, it is more likely caused by an unwillingness any longer to countenance the inhumanity of present policy and by the realization that addicts as "human beings in distress are morally entitled to the best help that can be offered them. . . ."[105]

SUMMARY

In the United States it is not, strictly speaking, a crime to be a drug addict. Yet this is the practical effect of the statutes that make it illegal for the addict to possess the narcotic he craves, and of regulations inhibiting (virtually banning) the prescription of these drugs to addicts by physicians. The addict's consequent illicit purchase of narcotics clearly constitutes a victimless crime as the concept is defined in this book. The addict is unlikely to complain against his illicit provider, and hence the laws banning such transactions are highly unenforceable. As in the case of abortion, a powerful illegal traffic in the demanded commodity arises; here the profit incentives are tremendously heightened by the continuous nature of the addict's demand and by his almost unlimited vulnerability. As in the case of homosexuality, the addict role may often take on primacy, as the entire existence comes to be centered around the need to finance and supply the drug habit.

The effects of this situation, in shaping the addict's self-image and behavior, are profound. The need to counteract law enforcement efforts and to maintain continuous contact with illegal drug sources, together with the enveloping and long-term nature of the shared adjustment problems, lead to the development of a special addict subculture. The problem of drug addiction can be seen, then, as embodying -- in perhaps even more extreme form -- tendencies observed in the examples of abortion and homosexuality. The unenforceability of the law, the growth of a thriving and well-organized illicit traffic, the secondary deviance on the part of the offending individual, the development of criminal self-images, and the evolution of a large-scale deviant subculture are all present.

In recent years there has been an increasingly strong current of professional opinion asserting that addiction should not be considered a crime at all but, rather, a disease. It is contended that treating the addict as a patient rather than as a criminal might drastically reduce the secondary aspects of the narcotics problem. Reform proposals aimed at undercutting the illicit traffic in drugs and putting most addicts under medical care often include the possibility of medical provision of low-cost drugs where that is deemed necessary. Such plans are still the subject of much controversy, but compromise measures (including greater judicial discretion in sentencing of drug violators, more and better treatment programs, and compulsory civil commitment for treatment) have already been enacted in some jurisdictions. The prospects for more thoroughgoing reform will depend largely on the overall attitudes toward addicts and addiction developed in the concerned professional groups and disseminated to the public at large.

NOTES

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4. Isidor Chein, et al., *The Road to H: Narcotics, Delinquency, and Social Policy* (New York: Basic Books, Inc., 1964), p. 356.

5. Helen M. Hughes (ed.), The Fantastic Lodge: *The Autobiography of a Girl Drug Addict* (Boston: Houghton Mifflin Company, 1961), pp. 113-14.

6. See Alfred R. Lindesmith, *Opiate Addiction* (Bloomington: Principia Press, 1947).

7. Hughes, *op. cit*., pp. 127-28.

8. Chein, *et al*., *op. cit*., pp. 246, 347-48.

9. Expert Committee on Addiction-Producing Drugs *Seventh Report*, World Health Organization Technical Report Series No. 116, 1957. As reprinted in President's Advisory Commission on Narcotic and Drug Abuse, *Final Report* (Washington, D.C.: USGPO, 1963), p. 101.

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22. Chein, *et al.*, *op. cit.*, p. 78.

23. *Ibid.*, p. 92.

24. *Ibid.*, p. 187.

25. *Ibid.*, pp. 268, 273.

26. John Clausen, "Social and Psychological Factors in Narcotics Addiction," Law and Contemporary Problems, 22 (Winter 1957), 34.

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30. U.S. v. Behrman, 258 U.S. 280 (1922).

31. Linder v. U.S., 268 U.S. 5 (1925).

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WHAT IS DRUG ABUSE? IS THERE A DEFINITIVE ANSWER?

Daniel X. Freedman*

This is not an easy topic. There are complex semantic histories behind the term "addict" and international bodies of experts have long attempted to bring some clarity to the terms we use. The simple facts are that there are a variety of settings in which individuals misuse drugs, whether these are prescribed or illicitly procured. Certain drugs are more likely than others to lead to misuse and to a range of consequences from toxicity to dependence and disruption of the conduct of personal or social life.

Behavior which we call misuse may range from unwise self-medication or unwise lay prescription (the wife takes the husband's antibiotic to which she is allergic), to passing, pushing, or consuming pills for kicks, relief, or for avoidance of tension. Certain drug dependencies, called addictions, involve drugs which induce stressful symptoms in their absence and, hence, add a further motive (physiological symptoms and stress) to drug-seeking behavior. There are a variety of toxic, accidental or physical effects (let alone social, religious, legal and economic ones) which may be associated with (or less frequently, a direct consequence of) drug-taking.

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The topic does plunge into a variety of what are, in fact, quite different issues. It is clear, however, that the definition of the abuse of drugs is most frequently the definition of an observer. Often we are concerned with whether or not an individual's use of a drug--whether it brings him pleasure or problems, or both, or neither--happens to be offensive to his wife, his family, or his employer, or neighbors. Thus, almost all of us are keenly concerned with the social effects of drug-taking. We judge its desirability (apart from the specific somatic and behavioral effects and the risks entailed) in terms of individual self-regulation, utility, comportment and development, and also in terms of perceptions of others--which are not always accurate.

If drugs did not simultaneously affect both private and public behavior and provoke value judgments about pleasure, and if they did not influence a gamut of social, legal and economic interactions, we would neither be as concerned nor as confused as we are. As a society, we tolerate a variety of brutal accidents, conditions leading to deprivation and depravity for segments of the population, and we approach a range of health issues with far less confusion and panicked perplexity than we currently show for drug problems. When "drugs" were equivalent to narcotics and when both were isolated either to a few slum areas or to an upper class or intellectual bohemian elite, we could treat the issues as not really impinging on the fabric of aspects central to American life. The point is that drug use, misuse, abuse, dependence, or physical addiction, all impinge on a variety of both individual values and social behaviors and consequences. In defining these issues, we have fundamentally to grasp precisely what our specific concerns and questions about drug usage may be, and expect that individuals will be at variance if not at odds with groups, and further that some groups of individuals -- cults and cliques -- will oppose general social values whether articulated informally or by law.

It is my thesis that we currently suffer from an epidemic of drug interest which is far more distracting than actual patterns of drug use and misuse. It is further my thesis that we are concerned, if not panicked, by exposure to the unpredictable, exposure of the unwary to all of this drug interest, and the bewilderning variety of increasingly popular patterns of drug misuse. The topic of drugs has been intruded (rudely for many of us) upon our normal concerns, bringing with it uncertainties and alarms and an expectedly high titer of irritation, as well as fear. That schools and legislators, and clinics and law enforcement agents, as well as industry, should have to confront some of these bewildering issues is taxing upon our energies. That young people today have yet another option for risk-taking about which to formulate attitudes and decisions is a tragic fact of contemporary life and I find it hard to see why anyone (and some do) would welcome it. Precisely how our society is going to either "cool it" or cope with and contain this epidemic of interest and of use in unclear.

Comprehension and analysis of these issues are forced upon us. It might help to remember that it is very difficult to have any kind of a rational attitude about drugs. It is natural that we would wish to isolate, avoid, overlook -- or, to counter doubt, overenthusiastically embrace -- drugs, because we have deep concerns when we seriously confront them. Every society worries about drugs which are available to it -- whether these are the products of technology or nature. Every society attempts to rationalize or socialize their use -- either condemning or demonstrating certain occasions for use.

Recreation is at issue. By the end of the day, after certain kinds of boredom and work and labor, one returns home and confronts a shift in circumstances. He may have a drink or a talk with his family. Whatever it is, he seeks a new communion with someone or something else as a relief from the constraints of the day. In this attempt to let go and relax, one shifts attention from one set of concerns to another. Now almost any drug which changes the way a part of the body feels can be used to help the process of shifting attention; some, which affect the way the brain works or the mind perceives have specific and compelling effects in this direction. What is dangerous, of course, if that individual motives can capture the release produced by this holiday from constraints, and individuals can employ the drug effects for escape in other than prescribed circumstances.

Further, no society is without deep concern about man's capacity to overindulge in pleasure. This is not to say that the addict, incidentally, is having pleasure; indeed, one of the greatest oversights of our era has been the failure to perceive the extent to which the addict is warding off displeasure. He may have started out for fun, status, or kicks, or have valued these drug effects, but his eventual primary use of the recreational drugs is to avoid displeasure. A human need to transcend constraints and displeasure is ever present and constructively or destructively exploited: Utopias are proposed in each generation; salesmen and prophets have always threatened establishments with visions, and lured the lost with proposals and potions for what they call love and liberation. The salient point is that every society must have some means by which to regulate escape (such as through communion or recreation) and confrontation. We have, then, been forced to attend to the use of drugs in our society.

What are the patterns of use which manifest themselves as drug problems? First of all we see a pattern of self-medication in which individuals self-medicate stuffy sinuses and headaches, or in which the young, in the need to study for exams or to sleep after overexcitement, are on occasion attempting to self-medicate with stimulants and sedatives. Secondly, we see experimentation with the available recreational drugs in which individuals may try in social groups or, less often, on more private occasions, to "see what it is like" -- and this is the most frequent kind of contemporary nonmedical drug-taking in youth. Third, we see the episodic recreational use of drugs over several years within an individual's biography; this may be an occasional (weekly or monthly) use of marijuana. People enter and leave various patterns of using drugs, so that today's recruits may be tomorrow's veterans and vice versa. Fourth, there is the dedicated use of drugs in which pharmaceuticals become central to existence, whether these are physically-habit-forming drugs or substances whose effects are habitually sought as a mode of coping with anxiety or inhibitions (tranquilization), or in the search for escape. This dedicated pattern of drug-taking may persist or recur for varying periods in individuals' lives.

Drug dependence may occur with or without viable harm -- or at least disruption. There have been life-long opiate and alcoholic dependent persons who were productive and did not "abuse" their dependence. Many of us have varying degrees of dependence on coffee or teas, and, without the intervention of ulcers or coronary disease, can cite no harm; yet we find it unpleasant to be deprived of our drug. The man who has his glass of wine and enjoys it may be said to have a habit -- he misses the drug when it is not available. But, we point out that he has not lost control over his habit. So individuals may live and adapt to their dependencies, showing different degrees of control over them. But the most frequent consequence among dependent individuals is a variety of evident physical, psychological and social impairments which few cultures can value.

Society as a whole, of course, cannot take into account the gradations with which each individual may control or regulate or be dominated by his usage of various drugs of choice. The major socially-sanctioned arrangement has been a properly regulated medical profession. Society should additionally be more careful about the adequacy and relevance of its laws and punitive sanctions (one mode of control), if it is to avoid creating more problems than it solves. A mobile and pluralistic society must exert effort to identify its risks and decide how to do this. Accordingly, it would be more useful in our society to make sound assessments of public health and social dangers which a prevalent pattern of use of one or another compound may in fact entail than to strictly, moralistically and abstractly construct definitions of different abuses or misuses.

What I am suggesting is that there are many aspects of our attitudes about drugs which are not only ambivalent and contradictory but which also lend themselves most readily to unexamined, tendentious statements and expedient or simple-minded laws and regulations. For example, if it is self-medication which generates casualties, we should perhaps do away with the possibility. This, again, would mean the strict prohibition of alcohol. Of course, the facts are that our society customarily permits consumers, rather than physicians, to prescribe alcohol, even though many individuals no doubt use it as a kind of self-medication. On the other hand, there is much concern today about the TV pharmacy and over-the-counter drugs which may have the sedative or stimulant effects that people seek. Yet we must recognize that people do seek relief from pain and anxiety; adults have a fundamental task to perform in adjudicating how their body feels to them and when professional help is going to be necessary.

This need to diagnose one's own problem, to learn to tolerate pain on the one hand and to interpret it and find some relief on the other, is not an easy topic to resolve through hastily constructed legislation. We cannot entirely abolish -- nor do I believe we actually should -- the intelligent self-management of everyday ills and ails. It is possible today to find mother's medicine cabinet responsible for the contemporary misuse of drugs -- but that well-stocked and advertised cabinet existed in the 1950's without any apparent epidemic of recreational drug use.

We should be careful about how we displace responsibility for unwanted patterns of drug taking -- whether to the Mafia, our own contradictions or youth's. The fact that our society bears a great burden as to how it will help to educate in attitudes towards reverence for life. If we legislate our network of drug manufacture, advertisement and consumption, we should not overlook some of the basic human needs which are to be dealt with currently.

Thus, we have to separate various quasi-medical uses of drugs, various patterns of drug use and misuse, and the variety of problems entailed where there is drug dependence. We should also be alert to what we mean when we are talking about "an addict" and what we properly should mean. Generally, we equate specific drugs and the addict, even though we know these differ. There are, indeed, many medically useful but socially or psychologically dangerous drugs; among these are those with physical effects producing tissue dependence. By this we mean a tissue reaction in which a second dose of the drug produces some kind of equilibrium (because in the absence of such a dose there is a reaction). The opiates (morphine, heroin, codeine), alcohol and barbiturates, clearly produce patterns of physical dependence in the appropriate dosages. Depending on dosage and dosage schedule (usually excessively high and frequent dosages), certain minor tranquilizers can produce drug-seeking behavior or a drug habit is evident as we use morphine and alcohol on appropriate occasions without producing anything like antisocial drug-seeking behavior. When used medically, addicting opiates are given to "patients".

Further, there are quite different phases (not necessarily sequences) in the use of drugs which produce dependence. This fact is no doubt complicating. Thus some individuals complain that we cannot predict their behavior or eventual demise in addiction simply because they have experimented with heroin, and are indeed not addicted or dependent; this is to a certain extent true. What society does say, of course, is that experimentation greatly enhances risk both to the individual and society; the individual's right to use a potentially dangerous drug and his right to use a potentially dangerous automobile do not, additionally, include the right to experimentation with either drugs or automobiles when this experimentation would increase risks either to the individual or society. The consequences of dependence or addiction are rarely the individual's burden alone to bear, and the costs of liability, even for our highway traffic and slaughter, is now leading to demands for public insurance. With regard to drug usage, society must formulate policies with regard to users and manufacturers of drugs, distributors. suppliers, and the abuse of specific drugs.

Many individuals insist that marijuana has been prevalent for five thousand years, and that it can be used without risk. This is partly true; but, of course, no drug can be used entirely without risk. If an individual employs a drug such as marijuana in controlled (though legally risky) circumstances, he is in a controlled phase of drug usage. The phase at which an individual begins to self-medicate with marijuana and the phase at which he begins to rely upon it for escape and tranquilization may be hard for the user or observer to differentiate. But the further phase when frequent daily usage may lead to cumulative and toxic effects is fairly easy to define as is the phase at which "more" of an effect is sought through the use of more potent forms of cannabis. It is these latter phases which begin to produce paranoid and hallucinatory states with some regularity and which represent more clear-cut stages of danger.

Where controlled pleasure is the purpose of drug taking and occasional use of low dosage is the pattern of disease, we do not know the optimal frequency of use over several years' period of time. This is a matter of dosage schedule and long-term and cumulative effects. We know some dangers for single high dosage and continuous heavy use of low potency marijuana. The dangers of high potency marijuana in a single or several dosages -- even though we cannot define these dangers in their entirety -- are toxic psychosis and poor judgment while intoxicated. But we do not know the dosage interval which is safe or the problem of cumulative effects with moderatly short intervals over a long period of time. Thus, while we arrest individuals for mere illicit possession of proscribed drugs, we are in the untenable position of finding it difficult to factually and objectively judge what role drugs might be actually playing in the possessors' general behavior. Indeed, we assume a harm that may or may not be justified on examination of individual possessors of marijuana. The best way to protect individuals and society is still to be determined.

Whatever the rank order of dangerousness, temptation or lure of a variety of different classes of drugs, it is clear that our major public health problem with drugs is alcohol, and that our knowledge of its misuse can offer us the general principles by which we could specify what we will encounter as general problems with other drugs. Perhaps what is most crucial to any drug-taking is the way in which individuals tend to manage the effects of a drug.

Within limits, the effects of any drug depend very much on what purpose one has when taking the drug and how the occasion of drug-induced behavior change is to be managed and experienced. Industry is properly concerned about having any person high on speed roaming around dangerous machinery -- at the very least it is difficult to predict his intentions and his judgment. But we should not forget that governments and armies have used pep pills to have pilots fly yet another mission, nor that our astronauts were trusted to use amphetamines -- indeed instructed to -- for specific purposes. Nor does the presence of an opiate within the body mean that performance need by impaired -- this depends on tolerance and motivation.

So -- within limits -- the issue of the intentions of the individual are crucial. His capacity to know, understand and control his intentions (a prediction which intrinsically can never be too certain) becomes crucial as his link to habit, judgment and rationality is loosened by chemical effects on the brain. Thus we have to assess society's capacity to help bridge whatever dimunution of control a drug induces. Society does this by reinforcing the definition of specific purposes for which the drug may be ingested and its effects managed. The extent to which one can reliably predict that society's wanted behaviors will be the actual behaviors of a drugged individual ranges with individuals, occasions, drugs and groups. Other calculable variables are the drug (its dosage and dosage schedules); the drug-taking occasion and the tasks to be performed in it; the social constraints or lack thereof in the regulation of performances; all are complex factors which would have to go into a prediction.

These various complex links of drugs to behavior and social values means that potentially the use of drugs affects the whole fabric of society; for example, legal regulations; workmen's compensation adjudications; behavior of parents, teachers, physicians, health workers, scientists and others; legislation; law enforcement; the courts and corrections. So, we deal with a broad public health issue which has involved many different segments of our society. With the present situation we can no longer lock up the problem into one or another isolated Federal bureaus with the hope that the worst of the problems or the most unwanted of them will stay out of the sight of the majority of us.

How did we get here? What is it that brought us to pay attention at last to the issues of drug misuse? We know that in the early 1900's opium addicts were often middle-aged, middle-class women who had been taking tonics which happened to be laced with a bit of opium. We know that the Harrison Narcotic Act, passed finally in 1914, was not truly meant to root out these individual sinners but rather grew out of a variety of high-level concerns about the problems of international policy involving our investments in the Far East and the behavior of oriental smokers. Few of us clearly comprehend the history of our drug laws or the ongoing history of international drug regulations. Yet we can recall that Commissioner Anslinger and the Bureau of Narcotics had been the sole repository of judgments on the dangerousness of illicitly used drugs. He was quoted as being of the opinion that marijuana was not dangerous and again, in 1937, that it was the chief cause of crime. The testimony at that time against classifying marijuana with heroin was opposed primarily by the birdseed lobby (which used cannabis seeds for bird food because it made their coats slick (not because it made them sing). Few medical or other opponents appeared to testify. The facts are that a variety of considerations other than public health or problems of actual crime against persons and property have dictated our patterns of drug control.

General ignorance relating to these matters has had consequences; drug problems were largely left to a handful of "experts" in law enforcement and other agencies. It was when the children of the culture-bearing elite began to use drugs -- and more crucially when commentators in the media reacted -- that the current drug problem surfaced and engaged knowledgeable psychopharmacologists and educators. The media -- such as Time and Life or Playboy and the daily press -- advertised the chief drug of interest. Between 1960 and 1966, this was LSD. What was a fairly small and localized epidemic of drug interest and use among select populations was rapidly disseminated. This subsequently had the effect of stimulating a style or a fad as these various journals continued to mythologize (hence prescribe) what was the prototypical youth and their culture. This was also linked with all the trappings and trippings of psychedelic go-go, with its emphasis on immediacy, "now", vividness and self-centeredness, and salient spoofing of smugness.

LSD is essentially no different in its effects than mescaline. It was vividly described by Havelock Ellis in 1898, and was tested in this country in the 1930's without any epidemic of drug trials, experimentation, misuse or excessive interest. It is difficult to account for the fact that this did not happen; an editorial in Lancet on Ellis' report indicated that if the public ever did get ahold of this, it would be a problem for the streets. Why is it that we have a problem at this time? No one is clear on the answer to this. But given the rapidity with which styles and information can be conveyed -- or reacted to -- it can become significant, imitated and consequential in terms of public style and habits.

Serious early experimenters were either curious or attempting to seek some special inner-comprehension, new perception, or mystical state. But we should not be so gullible as to believe that this is any longer the key motive for current drug experimentation. The message has been replaced by fad.

The epidemic quality of drug excitement which precedes drug use and misuse is important to comprehend. With excitement will come a variety of invested social roles -- drug experts (whether they be writers, scientists, physicians, ex-addicts, do-gooders or users). The consequences are a wealth of activities, ranging from conferences and half-way houses and various groups to press reports. None are unlikely to make it possible to accurately define the nature of problems which are talked about with such intensity.

It was clear that by 1966 LSD use was peaking out (not, of course, disappearing), and that the rate of increase of use was at least being contained. Most experts today agree that any small subgroup of LSD users will have about a two-year history of concentrated usage; the drug itself becomes less interesting to the users; some grow into other interests or responsibilities or both; some perceive various risks for themselves in the drug life, and all have perceived casualties.

Between 1966 and 1968, penalties escalated for LSD possession and use; there was intense publicity about possible chromosomal damage. Attention shifted to discussions about marijuana and the practice of trying marijuana became topical. There was an unanticipated consequence both to the intense propaganda that marijuana was not as dangerous as our laws indicated (true) and to the increasing experimentation with it on the part of college youth. An attitude of carelessness and a disbelief in "authority" escalated; the patina of safety and accusation of establishment hypocrisy around marijuana spread to all drugs. There followed the increased use of amphetamines ("speed"), intravenous experiments generally, and "pot and pills" (multiple drug-taking emerged as critical). In general, there was an increased interest in a life style which incorporated experimenting with drugs. Between 1968 and the present, multiple drug experimentations on the one hand, and marijuana experimentation especially, have spread to a variety of ages and subgroups and locales in this country.

It is crucial to understand this epidemiology. We find experimentation on both Coasts with a number of new compounds, and through the press and youthful travelers, they spread from the Coasts to the heartland's urban centers and from there to the various campuses and counties; from older drug experimenters, the pattern and interest in playing with drugs drifts down to younger age groups. The epidemic in part is sustained by the panic reactions of observers; the press and legislators, and the excitement of a new thing which blends so well with all the highly publicized mythology about youth subcultures (from the psychedelic to the hippie, from the radical to the protester).

What should be focused upon is the role of the individual carrier and propagandizer. Many populations and subcommities stay immune from any particular drug problem -- not because supplies could not be tapped -- but because there are no individuals who are demonstrating and carrying the drugs. The astonishing mobility of individuals in our society can rapidly carry a drug subculture with all its follies and ferment into schools, factories, clubs or wherever subgroups of people are related.

To have drug abuse, drugs must be available, interest must be generated, and a market created. Where this occurs, the unwary are exposed simply because of another group's demands for drugs. As the population at risk enlarges so, too, will the casualties and unwanted patterns of drug-taking. So, while an individual's biography with respect to drugs should not in itself alarm industry or any other group, it does seem pragmatic explicitly to define unwanted behaviors. These need not be labelled criminal, sinful, or medically dangerous. Rather, they simply should be labelled as undesirable.

Given all the unpredictabilities and risks entailed even in socially sanctioned drug-taking, the industrial plant or school is not the place for proselytizing for or consuming recreational chemicals. There is no reason for an organization dedicated to work or learning to have to adapt to new drug problems. Even in their highest and most developed forms, recreational drug-taking belongs in some other time and segment of society than the work arena. Thus, while defining undesirable behaviors such as "drug abuse", it should be possible to deal realistically with issues in one's household or community with regard to proscribed behaviors without at the same time unduly restricting individual rights. Upset to the community, as well as certain limits on the degree of acceptable individual inefficiency or danger, provides a warrant for proscribing the occasion of nonmedical drug use. The proscription does not also proscribe rehabilitative efforts, preventive efforts, and humane counseling.

We have today an unhealthy and exaggerated, if not lurid, interest in drug issues. We shall have to foster an environment where there is less interest in self-experimentation with drugs, more interest in self-respect and more awareness about our careless use of alcohol, nicotine and psychotropic agents. We shall have to convert drug panic into concern, and both into patterns of more selective and sufficient methods of encouraging healthy drug-taking and of dealing with the victims of unwise drug use.

While we can define unwanted drug use and differentiate it from unwise or unhealthy drug use, the issue is always that of human behavior. While any group can readily define appropriate and inappropriate behavior according to its own needs, it seems imperative that all groups in our society go to the trouble and confusion of sorting out the issues of drugs, persons, occasions, desired and undesired outcomes, and appropriate social responses, if society is to deal effectively with the drug problem. It is to be hoped that we can do this with some attention to reason, with come comprehension of human folly and human potential, and of our individual roles in it.

DRUG ABUSE AND LAW ENFORCEMENT

Charles Delaney*

The word "protection" in the minds of many citizens has come to mean the same thing as "law enforcement." Citizens believe that their property and lives will automatically be protected if the laws are enforced by the police. But by "enforcement" what the average citizen means is that he wants police officers to arrest someone else before they break a law. During the course of a day, police officers do not look around neighborhoods and other public places in order to arrest people who might break the law, however, in the minds of many citizens that is exactly what they expect police officers to do.

A woman who calls the police station, when she is in the middle of an argument with her husband, often does so in order to get the police to "protect" her from what her husband might do, not what he has done. If young people are out late at night, law-abiding citizens expect the police to "pick them up", not because they have done anything to harm the lives or property of others, but on the general precautionary principle that if they are not "picked up" they might get into trouble. Citizens want police officers to arrest or jail an alcoholic, not because he has hurt himself or anyone else, but just to "be on the safe side" in the event that he might do so.

A badge, a uniform, a night stick, a gun, and modern means of investigation and communication do not transform an ordinary human being into an omniscient one. The police officer cannot tell from looking at people whether or not they *might* break a law. However, the assumption on the part of citizens that they have a right to expect police officers to "protect" them from *probable* harm or loss of property has placed police departments in the position of having to *predict crimes* or illegal acts before they occur. Since it is impossible for police officers or anyone else to know the motives of people simply by looking at them, talking with them or questioning them for short periods of time, and since it is very unlikely that someone about to commit a crime will come up to a police officer to tell him his intentions, the police have been forced, in order to meet citizen demands, to become "prediction" officers. Police departments have generally responded to "prediction" demands by forming "special units" within the department to *uncover crimes before they happen*. Because citizens want to be "protected" from what *might* happen to them, police have moved into the paradoxical position of now having the capability of knowing through "special units" when there is higher degree of probability some crimes *may* happen but being unable to legally enforce the law (make arrests, etc.) until the crime has *actually* been committed. "Special" police units may give psychological reassurance to the citizenry when they believe that these units will be able to act as a crime deterrent and keep some crimes from being committed, but the crime statistics remain virtually the same -- even with a high degree of probability that a crime may be committed, the police are still in the position of having to make arrests *after criminal behavior has actually been exhibited*. The result is that the same number of crimes are probably committed with

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"special units" in police departments as are committed without them. This is particularly true if the "undercover" agents within special units remain anonymous (or undetected) among potential law breakers.

Even when mass arrests can be made from "undercover" or "special unit" activities, it is not at all clear that this has a significant impact on such massive problems as drug abuse in our society. If everyone who uses drugs or is a part of the drug problem were to turn himself in to the police tomorrow, we would still have drug problems as long as there are people in our society who want to take drugs. Drug injestion, regardless of the type or amount, except in rare instances, is a voluntary decision. As long as people want to take drugs all the laws and "special" police units in the world won't make any difference. If glue sniffing is made illegal, they'll try marijuana; if marijuana is made illegal, they'll try amphetamines; if amphetamines are made illegal, they'll try some other substitute. There are any of a variety of ways people can drug themselves if they are determined to do so. Therefore, when the police make arrests, even massive arrests, citizens are not protected from the possibility that their own children might ultimately decide to use drugs. This fact is becoming somewhat more accepted now that middle-class, well-educated young men and women are becoming drug abusers. The drug-user in today's society cannot be identified by the way he dresses, the way he talks, the kinds of professions he may be in, etc. The use of drugs is not limited to any socio-economic group within our society.

Some citizens still think of the drug problem as being related to a few junkies, pushers, drug addicts, drug freaks, etc. They believe that if the police arrested "all of the weirdos" the drug problem would be a thing of the past. But, as it turns out, many drug addicts and drug users in today's society are not "weirdos". The housewife who takes several aspirin a day, drinks 10 cups of coffee, and takes a sleeping pill at night is just as much in the drug scene as a young high school student who occasionally smokes marijuana. In order to enter the drug scene, all that most children have to do is open the door to the home medicine cabinet or take a pocket full of change down to the local pharmacy or grocery store.

The job of decreasing drug abuse problems will not automatically come about with the passage of additional drug laws or formation of "special" police units. Laws will not prevent a young person from experimenting with drugs he finds in the home medicine cabinet; laws will not prevent people who want to take drugs from taking them.

Responsibility for solving the drug problem has been placed at the feet of local law enforcement officers and agencies when, in most instances, that responsibility should lie elsewhere. Perhaps one of the most difficult aspects of police work is the readiness with which people shift responsibility to the police officer for solving their problems. As soon as the police officer arrives upon a scene, the responsibility for making decisions usually shifts from those directly concerned to the police. When someone has a car accident, responsibility shifts to the police officer to decide what happened in the accident and to make the proper report; when a child runs away from home, the police officer is given the responsibility for finding the child and returning him. Now that our society is worried about drug abuse, the responsibility for doing something about that problem has been shifted to a large extent to the local police, who are expected to "protect" people from further drug problems. But the experienced police officer knows that if the drug problem is to be alleviated citizens themselves must assume the major responsibility for their own behavior.

NARCOTIC ANTAGONISTS: NEW METHODS TO TREAT HEROIN ADDICTION

Allen M. Hammond*

The rising incidence of heroin addiction and the generally discouraging record of attempts to rehabilitate addicts has fostered the hope that modern chemical wizardry will provide some means of inoculating addicts or potential addicts against the effects of heroin, thereby preventing drug addiction. But if a drug to block heroin addiction could be developed, to what extent would it help solve the drug problem, and would it be beneficial, to the addict and to society, to administer it?

The questions are not hypothetical because such drugs, known as narcotic antagonists, do exist; but neither are the answers obvious. Skeptics who doubt the clinical effectiveness of narcotic antagonists point out that drug addiction is a behavioral response to deep-seated emotional problems, and that administering yet another drug to "cure" those problems is a naive and simplistic approach. Others think that blocking heroin use with the antagonists will only cause addicts to switch to different drugs and will leave untouched the deeper problem of drug-seeking behavior. Those who have used narcotic antagonists in treatment do not promote them as a cure for addiction, but they do believe that these drugs can be a useful adjunct to psychotherapy and a significant means of preventing heroin addiction, especially among adolescents. The whole issue is likely to receive much more attention;

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*A. L. Hammond, "Narcotic Antagonists: New Methods to Treat Heroin Addiction", Science, Vol. 173, pp. 503-506, 6 August 1971. Copyright 1971 by the American Association for the Advancement of Science, which has given us permission to use Mr. Hammond's article for IDEAS.

President Nixon's newly appointed coordinator for drug abuse prevention, Jerome Jaffe, has included antagonists on his list of potentially important treatment options. Funding for research on these drugs will apparently increase.

Narcotic antagonists are effective against heroin and other narcotics because they prevent those drugs from reaching the nervous system; antagonists differ, for example, from methadone, a synthetic narcotic, in that they themselves do not have narcotic effects and are not addictive.

The two narcotic antogonists now being used in experimental treatment programs are cyclazocine (a benzomorphine compound) and naloxone (N-allylnoroxymorphone). A daily dose of about 4 milligrams, given orally, of cyclazocine, which is the more widely used, will block both the habituating effects and the euphoria, or "high," from heroin for 24 hours. Patients are built up to this blocking dose gradually over a period of several weeks and in the early stages often experience dizziness, headaches, and other side effects -- sometimes including hallucinations. Once established on the blocking dose, patients who miss their daily dose report experiencing headaches and sensations akin to "electric shocks." At two and three times the doses normally used in treatment, cyclazocine apparently can have an effect similar to LSD, only more unpleasant. Cyclazocine is slightly habituating, in the sense that mild withdrawal symptoms (the electric shocks) occur when its usage is discontinued; but neither it nor naloxone is addictive. The narcotic antagonists, unlike methadone, do not satisfy an addict's craving for drugs, and, despite side effects, treatment with these drugs is for the addict very much like being drug-free. In fact, many former addicts reportedly test the antagonist from time to time by injecting heroin, because they "don't feel anything" with the antagonist.

Naloxone has far fewer side effects than cyclazocine and apparently does not require a period of gradual accommodation. Pharmacologically, it is in many ways an almost perfect antagonist. It can be used to treat heroin overdose and has been licensed for this purpose by the Food and Drug Administration; *recovery from the effects of heroin overdose usually begins within a few minutes after naloxone is injected. For the treatment and prevention of addiction, however, the drug is not ideal because its antagonist effects do not last as long as those of cyclazocine; more than one dose per day, or clinical supervision during part of the day, is necessary. Naloxone is not very effective in oral form, thus doses of 1000 milligrams or higher must be used. According to those who have used it, the drug has a noxious taste that is impossible to hide.

Cyclazocine and naloxone are believed to work by attaching themselves to sites in the central nervous system known as morphine receptors. Because the antagonists have a greater affinity for these receptors than the narcotic drugs do, the latter are prevented from reaching the nervous system, and their effects are blocked. This blockade can be surmounted, but only by injecting extremely massive doses of narcotics. Several drugs other than cyclazocine and naloxone are known to have antagonistic properties, but many of them have unacceptable side effects as well. In contrast. the so-called pure antagonists, such as naloxone, have

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* Neither cyclazocine nor naloxone has been approved for the treatment of addiction, and both are available for this purpose as investigative drugs only.

apparently no pharmacological properties in their own right except to block narcotics.

Clinical experience with narcotic antagonists at the present is limited -- a consultant to the newly constituted Drug Abuse Prevention Office of the White House estimates that only about 200 persons have been treated with these drugs. Nor are the antagonists ideal, in the forms available today, because they have a relatively short active lifetime within the body. Other possibilities for blocking drugs may exist, and it may be possible to chemically modify cyclazocine and naloxone to obtain forms that will act longer. Even in their present form, the drugs can probably be packaged in a plastic time-release capsule or in some other preparation that would allow sustained action -- from a few days to a month. But very little research has been done on these possibilities to date, in large part because of a lack of funds. The drug companies that developed the antagonists (Stirling-Winthrop for cyclazocine, and Endo Laboratories, a subsidiary of DuPont, for naloxone) are reluctantly making the drugs available for experimental use, and are doing some research as a "public service" and public relations gesture; but they have no great interest in narcotic antagonists because the potential market for these drugs is not large.

The federal government supports most current research on antagonists, although some state governments, notably New York, also finance research. In the fiscal year just ended, the National Institute of Mental Health (NIMH) funded some 32 research projects totaling $524,000, with the largest chunk of money devoted to clinical studies. More federal money is likely to become available, however, since the White House Drug Abuse Prevention Office, headed by Jerome Jaffe, is apparently going to recommend a major research and development effort aimed at finding a 30-day blocking drug for heroin, as well as expanded clinical trials.

But NIMH may lose some of its initiative and control over the research effort. By earmarking funds for specific purposes at the White House level, Jaffe and his staff will have a lot to say about how the research is done. One plan that is currently under discussion, for example, is to bring together several research groups, including some from the drug industry, and contract with them to develop the long acting forms of the antagonist. Contract research, although common in other areas of research, would be a novelty in the pharmaceutical field. Several major drug firms have indicated an interest in the project, even though nothing definite has been agreed upon yet.

Supply Problems

The new drug office in the White House will also have to contend with a variety of problems in supplying the narcotic antagonists. For example, one constraint on any operational program using naloxone is its expense and lack of availability. Naloxone is derived from thebine, a chemical present in small amounts in opium; it is correspondingly expensive, and, according to most investigators, hard to come by. It took one New York research group some 18 months to obtain sufficient quantities from DuPont for a clinical trial. Federal officials insist that adequate supplies are available for experimental use, and officials at the Bureau of Narcotics and Dangerouse Drugs, which establishes production quotas for investigative use, maintain that closing the Turkish poppy fields will not make it possible for individual companies to get enough raw materials in the future. But difficulties in obtaining a supply of opium may well provide companies with another disincentive to produce naloxone and similar compounds and a convenient excuse for not doing so.

Some research into new narcotic antagonists is already under way, with promising early results. One compound being studied is closely related to naloxone and is also derived from thebine, but it appears to have some advantages over both naloxone and cyclazocine. The new drug, known as EN-16-39 (*N*-cyclopropylmethylnoroxymorphone), is undergoing preliminary tests at the Addiction Research Center (ARC) of NIMH in Lexington, Kentucky, where the use of antagonists for the treatment of narcotic addiction was first suggested and tried. The compound has already been tested in animals at Endo Laboratories on Long Island and is being tested in human subjects during the current ARC trials. According to William R. Martin of ARC, the drug is about twice as long-acting as naloxone, and, although it does have some side effects, they appear to be far fewer and less severe than those associated with cyclazocine. Because it is also more effective orally than naloxone, the required dose (and the cost of the drug) appears to be about one-twentieth that of naloxone.

Most of the treatment programs using narcotic antagonists (see below: "Addict Treatment Programs") are restricted to patients who appear to be highly motivated to stop using drugs. But even with these patients a wide variety of problems are often encountered, including high dropout rates during the early stages of treatment and the use of other drugs. One of the chief causes appears to be that patients are compelled to face their problems and to deal with the realities of their social situations, however impossible. This may well be beyond the capability of large numbers of addicts, many of whom presumably use narcotics to avoid just those situations.

For how many addicts, then, are the antagonists likely to be useful? Methadone, because of its narcotic effect, is more appealing to many addicts, and the relaxed, jovial atmosphere of a methadone ward contrasts sharply with the tension, frustration, and anxiety that characterize a cyclazocine ward, according to one psychiatrist who has worked in both. Since there are more patients needing treatment than there are facilities available, antagonist therapy and methadone maintenance are not competitive methods of treatment at present. Yet it is still uncertain how many addicts can be induced, in the long run, to seek the more demanding type of treatment.

Three major roles have been proposed for narcotic antagonists in the treatment of heroin addiction. They might be useful in a preventive role in the treatment of the casual user of heroin who has a high likelihood of becoming addicted. They might be useful in the rehabilitation of addicted individuals who do not wish to be maintained on methadone -- both those who want to end a period of methadone maintenance and those just entering treatment for whom neither methadone nor a therapeutic community is acceptable. In this regard, antagonists might be a significant option in combination with a therapeutic community, perhaps making possible a shift to nonresidential programs. Third, the narcotic antagonists might be used prophylactically, more or less as a vaccine, in high drug risk areas during a crisis. An example of such a use would be to vaccinate large numbers of teenagers at a high school that was experiencing an epidemic of heroin use. Large-scale prophylactic use of antagonists in the armed forces has also been proposed -- as a kind of social experiment.

A number of objections have been raised to the use of narcotic antagonists, either in treatment or in the prevention of heroin addiction. Multi-drug use appears to be an increasingly common practice, even among heroin addicts, and the effect of widespread administration of antagonists might be to switch heroin users to amphetamines, cocaine, alcohol, or other drugs. Barbiturates, in particular, seem to be the drug of choice for many who would otherwise "mainline" heroin, because the calming, sedative effect is somewhat similar. But barbiturates are more addictive than heroin, and withdrawal much more dangerous -- apparently the mortality rate for unassisted withdrawal is as high as 15 percent.

Conflicting Views

There appear, in fact, to be two basic points of view among those who work with the drug problem. Critics of both the antagonists and methadone believe that the attempt to treat drug addiction medicinally, rather than by educational preventive measures and other "soft social programming," is characterized more by a concern for the welfare of society than for the welfare of the patient. Psychologists and ex-addicts involved with therapeutic communities have charged that the therapy provided in the antagonist programs amounts only to hand-holding, and that the addict's basic problems are rarely tapped and dealt with.

(The situation is complicated by the tendency of many partisans of a particular rehabilitative approach to be so committed to their own method that they cannot see the value of any other approach.) Some observers fear that antagonists, especially in their long-acting forms, will have a high potential for being used in socially irresponsible ways, whether or not those who developed them intended it.

Supporters of the narcotic antagonists believe that the urgency of the drug problem does not admit of waiting for ideal solutions and that the antagonists can provide help -- if not a cure -- for many who desperately need it. The psychiatric director of at least one antagonist program, while admitting that the cyclazocine and supportive therapy that she administers is little more than a crutch for the patient, points out the practical advantages -- the addict is not down in the gutter, not narcotized past the point of coping with daily problems, and not compelled to steal. Others point out that, while antagonists as presently administered will not stop those who want to use heroin, they can help prevent the impulse "fix," which may be of particular help to the adolescent in resisting peer-group pressure to use drugs.

Antagonists are not the solution to the drug problem. But since the problem seems unlikely to go away, the antagonists, as is true of other methods, can play a potentially important role in treatment. They can be, as one addict put it, "like having a friend in your pocket."

Addict Treatment Programs

Clinical trials of narcotic antagonists in the treatment of heroin addicts are taking place in a number of small programs that usually involve no more than 15 patients at a time. At Kings County Hospital in

New York City, for example, cyclazocine is administered on an outpatient basis, although patients must come in daily to take their dose. Before being admitted to the program, patients are required to attend group therapy sessions as part of an orientation and screening process to select likely candidates. Once admitted, they must spend 6 weeks in the hospital, being withdrawn from heroin with decreasing doses of methadone and then being gradually built up to the proper dosages of cyclazocine. Most dropouts from the program occur during this period, when patients try to face life without narcotics. Thereafter, they enter the outpatient program, which includes daily urine samples to check for drug use, counseling, and biweekly group therapy sessions in addition to the cyclazocine.

Perhaps the largest and oldest cyclazocine program in the country is that at the Metropolitan Hospital in New York City. After a hospital stay for detoxification, medical treatment, evaluation, and accommodation to the cyclazocine, the patients are treated on an outpatient basis. Patients come in only two or three times a week, rather than daily, and urine samples are spot-checked on the average of once every couple of weeks. The length of time required to build up to the prescribed dose is shortened to 4 days, by treating the initial side effects of cyclazocine with naloxone. But because it is still an experimental rather than a treatment program, patients commonly are kept in the hospital a total of 3 to 9 weeks.

One of the narcotic antagonist programs using naloxone is that at the Connecticut Mental Health Center in New Haven. The program gets around the problem of naloxone's limited period of action by operating as a day-patient facility. The patients, adolescents in this case, take part in therapy and vocational and recreational activities; at the end of the day, they receive their naloxone and leave for the night. But the antagonist is not the only method of treatment. The program relies heavily on what its director calls psychosocial intervention -- the attempt to replace the drug culture for the addict by making available to him alternative life styles, goals, and opportunities.

Although essentially all of the existing antagonist programs are still experimental in character and design, many of them report encouraging results. In some cases, patients who are still being treated with cyclazocine are working and living an apparently drug-free existence some 2 years after entering the program. The patients themselves appear to be satisfied that treatment with an antagonist is a good thing -- those contacted by Science expressed fears about being on the street again and said that they were glad to have that extra bit of security. -- A.L.H.

DRUG ABUSE -- JUST WHAT THE DOCTOR ORDERED

J. Maurice Rogers*

The continuing and justified alarm over illegal drug use by the young has obscured an underlying problem that is larger and even more threatening to society. It is an epidemic of legal drug abuse that is just what the doctor ordered.

Depression, social inadequacy, anxiety, apathy, marital discord, children's misbehavior, and other psychological and social problems of living are now being redefined as medical problems, to be solved by physicians with prescription pads. Psychiatrists as well as physicians of every other specialty now prescribe a wide variety of mood-altering drugs for patients with emotional, motivational and learning problems, and even the mildest psychological discomforts.

Model. Physicians who overuse psychoactive drugs are wedded to an obsolete medical model of human behavior -- the concept that psychological problems have medical causes. This viewpoint widens the physician's jurisdiction by classifying more and more persons as potential medical patients, and it allows an earnest medical healer to respond to all who seek his help.

The image of the physician as expert and benign begins to evaporate when we see physicians pushing psychoactive pills whose consequences are not fully understood into patients whose problems require human, not chemical,solutions.

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Ads. Doctors are strongly encouraged in their pill-for-every-problem syndrom by drug manufacturers who bombard them with advertisements in psychiatric and medical journals:

"WHAT MAKES A WOMAN CRY? A man? Another woman? Three kids? No kids at all? Wrinkles? You name it . . . If she is depressed, consider Pertofane."

And:

"SCHOOL, THE DARK, SEPARATION, DENTAL VISITS, MONSTERS, THE EVERYDAY ANXIETY OF CHILDREN SOMETIMES GETS OUT OF HAND. A child can usually deal with his anxieties. But sometimes the anxieties overpower the child. Then he needs your help. Your help may include Vistaril."

And this advertisement, which shows an attractive but worried-looking young woman with an armful of books, and describes the problems that face a new college student.

"Exposure to new friends and other influences may force her to re-evaluate herself and her goals . . . Her newly stimulated intellectual curiosity may make her more sensitive to and apprehensive about national and world conditions." The headline reads: "TO HELP FREE HER OF EXCESSIVE ANXIETY . . . LIBRIUM."

Such advertisements redefine normal problems of living as medical problems to be solved by drugs. Most small children, of course, are at some time afraid of the dark or anxious about school. A person may become depressed after personal loss, upon facing a new job, having to adjust to new conditions, or upon experiencing impotence in the face of increasing social turmoil. But the advocacy of drugs for such problems is socially irresponsible.

Pitch. Drug companies depend on this country's 180,000 physicians to sell their prescription drugs. The doctors must be reminded, cajoled, pampered. The drug industry spends over three-quarters of a billion dollars each year on advertising directed solely to physicians -- over $4,200 per physician per year.

The drug companies hold that their advertising is beneficial because it helps doctors learn about new drugs and new uses for old drugs. But many of the drug advertisements are grossly irresponsible, especially those that push psychoactive drugs -- sedatives, sleeping pills, tranquilizers, energizers and mood-elevators. They are irresponsible because they make broad, unsupportable claims of benefit and applicability. They are irresponsible because they expand drug usage into areas that call for human coping, not escape via drugs. They are irresponsible because they cajole the physician toward the notion of better psychological living through chemistry.

Last year there were more prescriptions written for psychoactive drugs than there were persons in the country -- and this does not include prescriptions in hospitals and clinics.

Role. It is clearly in the financial interest of the drug industry to maintain large numbers of persons on drugs just as it is in the interest of the medical profession to define more and more human problems as medical.

It is especially important for the drug industry to recruit new groups to drug use and to find new uses for its products. Flattered and seduced with bountiful free samples from the pharmacological industry, the physician increasingly assumes, with legal sanction, a role analogous to that of the pusher.

Many young people turn to dangerous illegal drugs to relieve unpleasant psychological states and to escape from personal conflicts and problems. When the young seek these goals with drugs bought from a street pusher we are greatly distressed. It is ironic that the same purposes are accepted as valid and desirable when such drugs are prescribed by physicians.

Stay. Because psychoactive drugs tend to produce a psychological dependence, people often continue to use a drug after it has served its immediate purpose because they are uneasy about giving it up and relying on their own resources. A club leader may take prescribed tranquilizers because the thought of giving a speech without them makes her anxious. A truck driver who has combated fatigue with prescribed amphetamines may come to expect himself to be tired when he drives without them.

Women use psychoactive drugs twice as often as men do. Many seek prescriptions for these drugs because they are lonely, anxious, dissatisfied or unhappy; because they are not as popular, thin, vigorous, interesting or beautiful as they have been led to believe they should be.

Among the most widely prescribed psychoactive drugs are the tranquilizers. These chemicals originally were developed for chronically disturbed psychotic patients. But every year they are used more and more in the normal life-sphere for personal and social problems that physicians and the drug industry have converted into medical problems. When someone dies for example, it is not uncommon for a physician to prescribe tranquilizers for the next of kin. The drugged family is then denied the opportunity to resolve a vital human experience.

Quiet. Nursing homes often use tranquilizers excessively to quiet elderly patients. Nelson H. Cruikshank, president of the National Council of Senior Citizens, has asked Congress to investigate this forced pacification program. Many doctors, says Cruikshank, "give blanket instructions to nursing-home staffs for use of tranquilizer drugs on patients who do not need them. Exclusive use of tranquilizers can quickly reduce an ambulatory patient to a zombie, confining the patient to a chair or bed, causing the patient's muscles to atrophy from inaction, and causing general health to deteriorate quickly."

One ad that appeared in medical journals shows a smiling, elderly woman sitting in a wheelchair, playing cards with other old persons. "SHE IS GOING STEADY WITH HER PHENOTHIAZINE TRANQUILIZER," says the headline. The ad obviously implies that phenothiazine will promote sociability. But research, ignored by this ad, shows that one of the undesirable side effects of these drugs is that they reduce one's desire and ability to interact with other people.

Calm. It is obviously very profitable to a drug company to hold exclusive rights to the only drug on the market for a certain disorder. Sales of the drug will increase if there is an epidemic of that disorder, or if the disorder comes to be defined so vaguely that more and more human problems can be seen as symptoms of it. There are drugs for "simple nervous tension," "worry," "anxiety," "lack of energy" -- maladies that are defined so broadly that everyone can recognize some of the symptoms in himself at times.

Ritalin and other drugs that normally function as stimulants (Dexedrine, Tofranil) have been found to have a paradoxical effect on certain children who suffer from the childhood disorder called minimal brain dysfunction. Such children are described as overactive, destructive, hostile and unmanageable. With daily doses of stimulant drugs they allegedly calm down, become more sociable, and increase their attention span. Unfortunately, the symptoms of minimal brain dysfunction are so vague they border on the normal hyperactivity of children. An alarming number of children have been given these drugs without the neurological and phychological examinations that are necessary for a diagnosis of minimal brain dysfunction. Exuberant children may have Ritalin prescribed primarily because parents want to quiet them down, or because teachers report that they are fidgety and inattentive in the classroom. In Omaha, Nebraska school officials recently discovered that between five and 10 per cent of the grade-school children in that city were being given medically prescribed amphetamines to modify their classroom hyperactivity or inattention.

Caution. The Food and Drug Administration has warned that these drugs are physiologically addictive and must be used with extreme caution. Despite this, their use under medical auspices expands alarmingly. About 250,000 children now take Ritalin daily: CIBA Pharmaceutical Company reportedly sold 10 million dollars' worth last year.

Dr. Leon Wanerman of the Mount Zion Hospital and Medical Center in San Francisco asserts that "the decision to place a child on medication is too often made without careful study . . . But if you put a child of seven on drugs for a protracted period of time, what are you telling a child about drugs and how they make you feel better?" Dr. Ernest Dernburg, also of Mount Zion, feels that such practices imply to the child "that he doesn't have the capability to get people to like him without an outside agent. And you can't arbitrarily assume that as an adolescent he will give up this pattern." Such a drug program, Dernburg believes, "would ultimately prevent the child from developing his own abilities to deal with his feelings."

Addicts. Physicians after decades of considering the heroin addict untreatable are now advocating treatment of this addiction by another drug, methadone, which is equally addictive. The advantages claimed for methadone are that it does not disrupt normal functioning as much as heroin, that it can be prescribed legally, and that it will reduce crime. But this treatment is a questionable exchange for the disorder -- withdrawal from methadone is as severe as withdrawal from heroin and there is questionable assumption that the antisocial behavior pattern of a heroin user will vanish once he is addicted to a legal narcotic.

The advocacy of methadone therapy for heroin addiction gives us a vivid *deja vu* experience: heroin itself was originally introduced by physicians as a cure for opium addiction. Similarly, cocaine was introduced to the European medical community as a cure for opium addiction (and for other things, including depression, digestive disorders, typhoid fever and alcoholism) in an essay by the then-young Viennese physician, Sigmund Freud.

Opium itself was once recommended in a medical journal as a sound treatment for alcoholism. In a Cincinnati Lancet Clinic article in 1889, Dr. J. R. Black presented his thesis in terms remarkably similar to those now used to promote methadone:

"Opium is less inimical to a healthy life than alcohol. It calms in place of exciting the baser passions, and hence is less productive of acts of violence and crime; in short the use of morphine in place of alcohol is but a choice of evils.

"On the score of economy the morphine habit is by far the better. . . on the score of decency of behavior instead of perverse devilry, of bland courtesy instead of vicious combativeness, on the score of a lessened propagation of pathologically inclined blood. I would urge morphine instead of alcohol for all to whom such a craving is an incurable propensity."

Purpose. An ominous trend is the increasing development and use of drugs to counteract undesirable effects of other drugs. For example, amphetamines are used for weight reduction and when side-effects occur -- shakiness and sleeplessness -- they are treated with barbiturates.

The pharmaceutical industry encourages this trend, as in the following ad:

"WHEN A TRANQUILIZED PATIENT GETS DRUG-INDUCED PARKINSONISM DON'T STOP TRANQUILIZERS, JUST ADD AKINETON." But Akineton has its own potential side-effects -- euphoria and disorientation among others -- and the physician may have to treat these with more drugs.

The effects of psychoactive drugs are multiple and complex. Some psychological effects are evident at once; others build up so gradually that they are difficult to detect. Some effects are specific, others are enormously diffuse. I strongly disagree with recent contentions that the Food and Drug Administration should lower its standards for approving new drugs ("They're Safety-Happy in the FDA and We're in Trouble" by Paul H. Blachly, P. T., May). Much is unknown about the effects of psychoactive drugs that already are on the market; much more must be learned about new drugs before they are made available to physicians and the public, even though this means delay in their introduction and use. It cannot soon be forgotten that despite warnings from some of their colleagues, hundreds of physicians in Germany and England continued to prescribe the drug thalidomide to pregnant mothers. It is incredible that it required more than 5,000 terribly deformed babies finally to halt this medical practice.

Politics. The future promises even more widespread legal drug abuse. Henry Brill, former president of the American College of Neuropsychopharmacology, advocated the use of drugs to control "pathological aggression," thereby reducing "crime in the streets." Given such conceptualization and the medical model for human behavior it is not hard to envisage a day when errant citizens will be required to take daily doses of drugs to control whatever behavior the current government considers undesirable.

The Office of Health Economics in London extrapolated medical trends in their report, Medicines in the 1990s -- A Technological Forecast. Their grim prediction was that "it is likely that by 1990 nearly every individual will be taking psychotropic medicines either continuously or at intervals."

It is time for an immediate examination of the legal drug culture, of the role that psychoactive drugs play in human life.

We must combat the medical-psychiatric model of human behavior that seeks a drug for every psychological discomfort and under which a person who is not continuously calm, anxiety-free, happy and content is defined as a medical patient.

We must question a medical approach in which psychoactive drugs are used as an easy solution, a cover-up, a simple, acceptable way to avoid dealing with personal and interpersonal problems. Such "treatment" is counterproductive: it tends to become self-perpetuating, it does not solve the underlying problems, it keeps the person from learning how to cope with his world, it often reduces a person's willingness to interact with others, and it may actually impair the body's self-regulating psychological functions. In addition, it lulls the medical and psychiatric professions into false security by suggesting that there is no urgent need for further research, no need for the development of more humanistic approaches.

Presto! One of the most disturbing effects of psychoactive drugs is that they convince the drug user and those around him that psychological problems have chemical solutions -- that relief is just a swallow away, that better psychological living can be achieved through chemistry, rather than by coping. The attitude that prompts one to seek psychological quick-change in a doctor's office can also lead one to a pusher on the street corner. That the medically prescribed drugs are standardized and chemically purer begs the question.

The drug-abuse problem is compounded by the pharmaceutical companies that seek new drug markets and bigger sales, that exhort everyone to feel better fast, and that persuade physicians and the public that unpleasant human emotions are abnormal and should be suppressed with drugs.

The drug-abuse problem is further intensified by those physicians who see themselves as universal healers, who take the easy route by prescribing psychoactive drugs without considering more relevant non-medical approaches. Appealingly simplistic solutions to personal distress are the hallmark of the unprincipled politician, the intolerant social reformer, the medical quack. From a responsible professional the public must demand concern for potential dangers and services confined to areas of competence.

The welfare of society is too precious to be entrusted solely to the hands of physicians. We may have been basing our trust on a myth of medical competence. Perhaps what may be needed in local communities is a citizen review board for medical practice.

MIND-ALTERING DRUGS AND THE FUTURE

Wayne O. Evans*

A study of man shows that throughout recorded history, and in almost every culture, people have taken chemical substances to change their mood, perception and/or thought processes. The earliest recording about such drugs seems to be the hymns of praise sung to "Soma," the magic mushroom of the Aryan invaders of India, found in the Vedas. These indicate its use came from northeastern Europe and had existed since 2000 B.C. Later, about 1500 B.C., the Eber Papyrus documents the use of wine by the Egyptians. The opium poppy, Papaver Somniferum, appears in records as early as 1000 B.C., and documents from Mesopotamia indicate the use of cannabis (Indian hemp) as a psychotropic drug at least 500 B.C. The ancient Indian civilizations of Mexico and South America used mind-altering chemicals, e.g., cocaines, tropines, harmines and indoles of various types. Farther west, the natives of the Pacific islands used betel and kava kava, while in Asia, natural products which yield ephedrine and reserpine were common in medical practices. Closer to home, we can consider our own history of opiate usage, laughing gas or ether sniffing parties, cocaine epidemics and a tradition of excessive use of alcohol.

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* Wayne O. Evans, Lt. Col. in the U.S.Army as well as a physician, is soon to be placed on temporary duty status with the staff of the Special Consultant to the President for Narcotics and Dangerous Drugs, Washington, D. C. We have the author's permission to use his article for IDEAS. It will be published, by Charles C. Thomas sometime in September 1971, along with a collection of other readings, in Psychotropic Drugs in the Year 2000: Use by Normal Humans, which Wayne O. Evans and N. S. Kline have edited. The article has also appeared in The Futurist, Vol. V., No. 3, June 1971, pages 101-104. The ideas expressed in the article should be interpreted as reflecting the opinions of the author and not those of the Army, the Special Consultant to the President for Narcotics and Dangerous Drugs or any other group with which the author is affiliated.

Obviously, man always has sought chemical methods to alter his mind and this tendency has not abated and may even have grown in modern times.

Psychotropic Drugs Pour into Market

Today, medicinal and biochemistry, animal and clinical psychopharmacology, neurophysiology and neuroanatomy are advancing at the same rapid rate as the other biological sciences. Thousands of chemicals are tested each year for potential psychotropic properties. Expeditions have been launched to such dissimilar environments as the upper Congo and the continental shelf in search of new plants or animals which might yield chemicals to alter the mind. New psychotropic drugs have the highest rate of entry onto the market of all types of drugs. Further, our techniques of testing new chemicals for psychotropic properties, in both animals and man, have been refined to the point that one would be hard pressed to name a mood, mode of perception of mental function which now is not testable and roughly quantifiable.

Due to this heightened skill in science and technology, we are achieving a potency and specificity of action in drugs which previously would have been impossible. As an example, K. W. Bentley has synthesized an opiate-like substance which is ten thousand times as potent as morphine. This means that the average effective dose for a human being is 1.5 micrograms to achieve an analgetic equivalence with the usual dose of morphine given for postoperative pain relief. Another example of the capability to produce more potent and specific drugs is the development of certain diazepoxides (Librium ®) which can induce sleep at a dose as low as 0.5 mg. We finally may have produced a compound which will live up to the fabled "knock-out" drops of spy fiction.

This greater potency and specificity of drugs comes from a knowledge of the interaction of chemical molecules with receptors on cell membranes, understanding of the affinity and activity of drugs for specific receptor sites, by using molecules with optimal, rigid shapes and appropriate positioning of ionic and polar groups, and by blocking metabolism or facilitating procursor formation. Drug molecules now are better behaved than they were in the past.

A convincing demonstration of this increased specificity of psychotropic drugs is seen in some of the anti-depressant agents, e.g., tricyclic amines. At the proper dose and rate of administration, they do not produce euphoria, but do ameliorate depressive states by reducing the uptake and inhibiting the binding of brain norepinephrine in storage granules of neurons.

Developments in neurophysiology also have contributed to our capacity to design novel and potent psychotropic substances. The chemical and electrical mapping of brain systems for the basic drives, e.g., hunger, thirst, pleasure, fear, sex, excitement, sleep, etc. are well advanced. The faith held by psychopharmacologists that a person's mood and his neurochemical state were equivalent terms from different viewpoints seems to be on the road to justification.

Public Acceptance of Drugs is Growing

Science alone is not responsible for the development of new drugs used in a culture. In order for a drug to be developed, people must want it and a social condition favorable to its use must exist. From the evidence of an ever-increasing consumption of psychotropic substances by people today this condition appears to be fulfilled. To gain a perspective in regard to our present social situation, we should remember the resistance to the introduction of anesthetics for childbirth, with its implicit assumptions that pain is "good" and that the "natural" inherently is "virtuous." Anti-psychotic tranquilizers were introduced into our mental hospitals as recently as 1955; in 16 years the previously ever-growing number of hospitalized mental patients has dwindled, to the point where in 1968 occupied mental hospital beds were at the same level as in 1947 in the United States. A more general public acceptance of psychotropic drug use is shown by the number of over-the-counter pharmaceuticals that are purchased. At a local supermarket one can buy drugs reputed to relieve tension, produce sleep, make one become more alert, relieve all sorts of pain, reduce motion sickness, fight fatigue, etc. Most people do not realize that aspirin is the second largest cause of acute drug death in the United States, that caffeine poisonings do occur from the tablets bought in drugstores or supermarkets, that anti-histamines in cold tablets can slow reflexes, or that the "safe, non-barbiturate, non-habitforming" sedatives they purchase can induce severe hallucinations at high doses. Finally, we must not forget the most prevalent, socially destructive and personally harmful psychotropic drug of them all, alcohol. To call a drug a beverage does not change its chemistry.

Public attention constantly is directed toward psychotropic drug use by mass media advertising, drug education programs, peer group pressures and advice from physicians. Consider how many ads you see on television, newspapers and magazines during a single day for chemicals to make you feel better, become more beautiful, or be the life of the party. Think of the recent flood of opinions you have heard about drugs from both the establishment and from the youth. In almost every town in the United States, drug abuse education programs have sprung up. Energetic, well meaning, but unfortunately, often relatively uninformed people have decided to tell "the truth" about drugs to young people who think they already know everything there is to know about them (4,300 scientific articles were published on psychotropic drugs in 1968 alone). Evidence of this information gap can be seen by considering references to "drugs" without mention of purity, dose, route of administration, schedule of use, situation-person-behavior-drug interactions, etc. The fact is that drugs qua drugs are not inherently "evil" nor do they convey "universal truth." Indeed, we have no data to show whether any of the social programs and educational schemes now underway will help to reduce the harmful use of drugs. This lack of evidence has not deterred these activities. Indeed, the programs could be increasing drug use by adding to drug advertisement.

Adults Who Warn Youth Against Drugs Are Using Drugs Themselves

Peer group pressures for drug use are not confined to the young. Recent studies have shown that almost half of middle class adults in the suburbs who occasionally have taken psychotropic substances did not receive them from a physician but from a neighbor or friend who told them that this was "just the pill to make them feel good." Ninety percent of all psychotropic drugs in the United States were not prescribed by a trained psychiatrist, but rather by some other type of physician who may be less aware of drug-behavior interactions. Further, many physicians are not current in their information about these new drugs. The deaths resulting from a use of certain anti-depressant witnesses this fact. Also, few physicians have been trained in the pharmacology of marijuana, heroin , LSD, STP, etc. Non-medicinal drugs aren't taught in medical schools. Indeed, parents and physicians who are telling children not to use drugs are themselves using mind-altering chemicals on a massive basis and, frequently, the drugs are not even received legitimately by prescription . When we give up alcohol and tranquilizers, we will reduce the hypocrisy of which the youth accuse us. Perhaps, then, a dialogue can begin.

Even physicians are not totally free from some responsibility for the present extensive use and misuse of phychotropic drugs. Studies have shown that young people who often were ill as children and were taken regularly to a physician and there received pills form the group most likely to enter the drug subculture during late adolescence. Yet some physicians prescribe psychotropic substances merely to satisfy the desire of their patients for some form of chemotherapy, without considering the full psychiatric implications of the complaints or the potential efficacy of the compounds.

In the United States in 1969, 90 million new prescriptions were issued for minor tranquilizers, 17 million new prescriptions for anti-depressive drugs, 12 million people had used marijuana at least once, and one calculates the consumption of diet pills, stimulants, aspirin, sleeping compounds with scopolamine and other psychotropic drugs by the boxcar load. We have lived up to the famous comment, "Man is the pill-taking animal."

Potent, Safe Euphorics and Aphrodisiacs Are Foreseen

In the near future -- say 20 years hence -- we could have available highly potent, minimally hazardous antipsychotics, tranquilizers, analgesics, antidepressives, euphorics, psychedelics, stimulants, sedatives, intoxicants, aphrodisiacs, as well as combinations of these drugs to expediently produce most mood states. There now are over 900 drugs listed as psychotropic by the National Institute of Mental Health and the list is rapidly increasing.

The production of non-sedated states of tranquility has advanced since the discovery of meprobamate (Miltown®) to its present form in the diazepoxide series (Librium®). It seems almost inevitable that this trend will continue. The introduction of pentazocine (Talwin®), a potent analgesic which produces a relatively minimal degree of physical dependence, heralds the probable development of a new class of potent, analgesic drugs which do not have physical dependence as a side effect. This development is continuing so that physical dependence should not be a major medical problem in the near future. Also, research has demonstrated that by combining an opiate with an amphetamine, one produces a greater potency of analgesia without an accompanying depression of vital bodily functions, sedation, or mental incapacitation. These two developments portend that shortly we shall have potent analgesic substances which will interfere minimally with one's daily life. Oral forms of these new analgesics with little dependence or sedation are under development.

The introduction of lithium into manic-depressive therapy is an exciting recent development. Although some types of manic-depression are refractory to any treatment and some depressive states respond best to a short series of electroconvulsive shocks, it appears that a combined therapy of tricyclic amines with a long-term administration of lithium will reduce the impact of this disorder. Further, lithium use has advanced our knowledge of "affect" disorders at a cellular level.

Need for Drugs Less Harmful Than Alcohol

Compounds to produce euphoria or psychedelic states seldom are discussed in "proper" pharmacological or medical circles. Yet, a member of the National Institute of Mental Health has stated that an urgent need exists to search for compounds which can relieve the tensions of daily life by giving a person the occasional opportunity to become intoxicated without the severe problems associated with the excessive use of alcohol. As population expands and recreational possibilities shrink; as the impersonality of a specialist-run, counter-intuitive society increases and meaningfulness of community life lessens; the tensions easily might cause an episodic desire by some to become intoxicated for a short while to feel wise, strong and loved. If we accept this unpleasant truth, the least we can do is develop compounds less hazardous for use than alcohol (potentially an addicting, physically harmful drug). Additionally, we must provide places and circumstances where these bouts of intoxication could take place, while minimizing the harm a person might do himself or his fellow man. Can we continue to tolerate the fatalities on the highways, overweight, liver damage, psychosis, broken homes, sex crimes, and crowding of public hospitals and jails caused by the unwise use of alcohol? The explorations of the cannabinols, and the extraction of tetrahydracannabinol as the active principle of Indian hemp, may be a possible first step in a search for new, less hazardous "anti-alienation" drugs and the creation of socially approved, peer-monitored "drag strips" for racing may be our best models for effective social control of intoxicant use.

Recent research on sleep, coupled with data from studies on depressed patients who have received a combination of an amphetamine and a monoamine oxidase inhibiting, antidepressive drug, has demonstrated that man can live quite well on four hours of sleep a night -- a fact well known to the Mogul Emperors. This, considered with the development of relatively safe sedatives of the diazepoxide type, should let us arbitrarily decide whether and when to be awake or asleep -- as long as we stay within the apparent physiological constraint of at least four hours of sleep per day. Consciousness may become optional and a matter of convenience, personally or for a society run in shifts to prevent overcrowding of limited facilities.

Hedonists' Dream May Be Fulfilled through Sex Drugs

Aphrodisiacs have a fascinating history. Perhaps for no other chemical has man sought so long and avidly. In examining a recent dictionary of purported aphrodisiacs, it was interesting to note that chemicals to aid the flagging potency of the male outnumbered those to aid the female by about 20-1. Mass media publicity of L-DOPA and PACA have alerted the public to the fact that the brain centers responsible for the triggering and maintaining of the sexual act already have been discovered. It is possible in animals, by either chemical or electrical means, to initiate the sexual act and have it continue without satiation for prolonged periods. Whether these sexual acts are pleasurable or not to the animal is difficult to know. However, if we combined a euphorogenic agent (to make the sexual act pleasurable), with a cholinergic stimulant (to provide the male an increased capacity for potency without ejaculation), and finally, stimulated the brain centers responsible for the initiation and continuation of the sexual act, we may be approaching the hedonistic philosopher's dream. In some sense, we already have aphrodisiacs (see Aphrodex®, Bennet Pharmaceutical). The only questions remaining are the particular combination of drugs, their ratios and the production of oral forms. If these drugs are developed and widely used, I cannot help but wonder what types of human interactions may result. Where is the warmth, affection and subtlety in a chemically driven liaison?

Peer Group Control Might Limit Drug-Induced Harm

The social consequences of chemically alterable behavior depends on the nature and source of the imposed sanctions. Thus far, through history, we have seen admonitions for individual self-control, prohibitive legal sanctions, peer group control, and, on occasion, imposed use of mind-altering drugs. Individual control is, I believe, a lost battle. The present evidence of the quantity of drugs consumed is proof enough. Prohibitive laws have been attempted since the Empress of China proclaimed the death sentence for opium users and, in Turkey, the use of tobacco was punishable by death in "a means acceptable to God." Our own more recent experience with prohibition of alcohol is additional evidence of the lack of efficacy of this type of sanction. Finally, 12 million people in the United States have used marijuana -- though many of the states have harsh laws against its possession. This seems to demonstrate that the threat of harsh punishment does not work well to deter use of psychotropic drugs. Few physiological effects of drugs could be as severe as their legal effects. Peer group control has been used as a sanction for chemical users -- sometimes to limit use to special situations and acceptable doses. Presently, in small groups, some young people learn to 'guide' each other in drug use and can exercise a rather superb degree of control so that group members seldom become too "high" on marijuana. Similarly, in Italy, a tremendous amount of alcoholic beverages are consumed, yet, there are relatively few cases of alcohol dependence or the various other ill effects that sometimes result from continued use of this drug. It appears that introduction of children to the consumption of alcohol in a family situation, during mealtimes, "immunizes" them against later excessive use. In Italy, the family encourages drinking but does not tolerate drunkenness. Perhaps, we should take note of this method in order to reduce drug-induced harm.

Drugs Could Be Used to Slow Social Progress

A frightening possibility exists that psychotropic chemicals could be imposed upon people without their consent or by social pressure. One must wonder if some of child psychopharmacology, as sometimes practiced, is not a form of chemical warfare against our children, and the spread of LSD from one spouse to another demonstrates that pressures for drug use are both close and powerful. Again, the development of incapacitating warfare agents of a psychotropic nature, by the United States and other countries, shows what can be done with these chemicals. At least most of the young have accepted the creed "Thou shalt not alter the consciousness of another without his consent". Are we as honorable? It is not difficult to envision a possible future in which tranquilizers, hallucinogens or euphorogenics, effective in the micro or nanogram range, could be distributed in an aerosol to quiet a "pre-riot" area. What would be the possibility of any social progress in a society in which the authorities might reduce people's level of agitation or disgust by chemical means? We must ask ourselves if agitation, conflict and violence are necessary precursors of social progress, or are these behaviors no longer tolerable in an inter-dependent, urbanized society?

Drugs Might Produce Dreams or Induce Forgetfulness

The distant future holds many promises -- or threats -- of memory drugs, amnesia chemicals, dream-producing agents, pills to increase suggestibility, and all manner of other chemicals to make one's phenomenological state a matter of convenience. Although much discussion has revolved around the possible development of drugs to improve memory, people seem to have overlooked the advantages of drugs which will destroy it. Heinz Lehmann has pointed out that the most pathetic aspect of old age is the sense of already having experienced everything. At a recent meeting, he quoted a patient as saying "a pickle doesn't really taste like a pickle anymore." Old age is a state of constant *déjà vu* and *déjà entendu*. To overcome this apathy of experience, we might use drugs to heighten the sensations of the elderly and re-establish their sense of novelty to experiences by producing a temporary condition of amnesia. Why not allow an elderly person to rest and conserve his resources for most of the week, but on weekends or special occasions, allow him the excitement produced by a stimulant and/or psychedelic compound with an amnesic drug as a bonus? Certainly, with this group, we are not concerned about dependence, or the other, usual fears associated with drug use by young people. Why should their lives be a constant, grey boredom waiting for death?

We can, if we wish, produce an individualistic "choose your mood" society or a chemically controlled tyranny or an age of ultimate hedonism by chemical manipulation -- or any other variant desired. Perhaps the real questions should be: "Can we choose? If so, who should choose? and Who will choose?" Technology is doing mankind a great service: It has forced him to define his morals, goals, and future. It has exposed him to his ultimate choice; "What shall I become?"

SOME CONSIDERATIONS FOR THE TREATMENT OF NON-NARCOTIC DRUG ABUSERS

Carl D. Chambers and Leon Brill*

INTRODUCTION

There has been no determination of the prevalency of non-narcotic drug abusers in the United States, nor have we had the means of ascertaining how much of these legally manufactured and distributed drugs have found their way into the illicit market. Independent figures and estimates do indicate this abuse is widespread, and that there is a constant supply of non-narcotic drugs in the illicit market:

1. Each year in the United States, 100,000 pounds of amphetamines and amphetamine-like products are manufactured. This is enough for fifty 5 mg doses for every person in the entire nation irrespective of age. During the same period of time, over 1,000,000 pounds of barbiturate derivatives are manufactured – the equivalent of approximately 24 one and one-half grain doses for each person in the nation – enough to kill them twice.
2. Half of the annual production of amphetamine base finds its way into the illicit market.
3. It has been estimated that in 1957 seven percent of our adult population was regularly using one or more of the psychotropic family of drugs, e.g., tranquilizers, sedatives and stimulants; but by 1967, 27 percent were doing so.
4. There are as many, and probably more high-dose intravenous amphetamine users in our large cities than there are heroin addicts.

Two general facts about current abuse of the non-narcotic drugs – amphetamines, barbiturate-sedatives and tranquilizers – emerge from the available patchwork of figures and estimates. First, amphetamines appear to be more widely abused than the barbiturate-sedatives and the barbiturate-sedatives more widely than tranquilizers. Second, of the three classes of drugs, the barbiturate-sedatives appear to inflict the most damage on the abusers' health and conventional functioning.

BARBITURATE ABUSERS

The first barbiturate, Veronal, was introduced into clinical medicine in 1903, and the short-acting barbiturates, which abusers in the United States tend to prefer – pentobarbital, secobarbital and amobarbital – became popular during the late 1930's and early 1940's.

It has been our experience that barbiturate abusers can be grouped into three fairly distinct types:

1. There are persons who, in order to deal with states of emotional distress, will abuse the barbiturates *solely* for their sedative-hypnotic effects, and in so doing remain constantly in a highly sedated state.
2. There are persons who, during the course of therapeutic usage, have discovered the paradoxical reaction which occurs when sufficient tolerance has been developed with the barbiturates. At these dose levels, barbiturates stimulate rather than depress, and the person begins now to take the drug for exhilaration effects.
3. There are persons who, during the course of abusing another class of drugs, ingest large amounts of barbiturates to alter the effects of the other drugs, e.g., to counteract the abuse effects of amphetamines. This frequently sets up a consecutive cycle of abuse, to enhance the effects of intravenous use of opiates, to substitute for an opiate during the times when opiates are unobtainable, etc.

While the barbiturates were believed to be capable of producing a psychic dependence (habituation), it took nearly half a century to convince the practitioners of clinical medicine that the barbiturates were indeed drugs of addiction if abused. Even with indisputable evidence of the addiction liability of the drugs, they did not come under effective control until the mid-1960's.

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TREATMENT CONSIDERATIONS

The Detoxification Phase

As with the narcotic addict and the alcoholic, the barbiturate abuser, regardless of type, does not ordinarily seek treatment until such time as his abuse has precipitated some crisis, e.g., the loss of a job, marital difficulty, a police contact, the loss of a drug supply, etc. Once the abuser does seek treatment or it is imposed, the detoxification phase of treatment, since it can be life-threatening, should occur on an inpatient basis.

> . . . Withdrawal of persons with strong physical dependence may be life-threatening, and can only be accomplished satisfactorily, and with reasonable safety, in a drug-free environment where hospital and nursing facilities are available. (A.M.A.[1]).

The gravity of the barbiturate abstinence syndrome is indicated by the occurrence of death following the withdrawal of secobarbital from a patient who had been using 50 gm of the drug daily (Fraser, et al.)[2].

The contraindication of abrupt withdrawal of barbiturates and the specific symptoms to expect from physically dependent persons are widely documented in the literature. Even a rapid reduction of the dose to which the person has become tolerant is considered dangerous. The general procedure for the medically controlled withdrawal process dates to the pioneering work done by Isbell et al.[3]

> . . . The amount taken also varies over a wide range, but most chronic habitués probably take between 0.5 to 2.0 gm of the drug daily (Isbell [4]).

This initial process is, of course, to establish with some degree of certainty the amount of drugs the person has been ingesting. After the "test dose" procedure of gradually increasing doses of barbiturates has ascertained the "stabilization dose," a gradual reduction in daily intake from that dose is indicated.

If the barbiturate abuser has concurrently abused other drugs which require a separate withdrawal regimen, the evidence is that multiple withdrawals can be conducted simultaneously without increasing the danger of abstinence from either.

Treatment During Initial Abstinence

The literature would indicate that once primary withdrawal has been completed – in two to three weeks – the rehabilitative and psychotherapeutic treatment of the barbiturate abusers is identical with that for the narcotic addict. While there is, of course, some pragmatic expediency in this approach, the authors' experiences would indicate some variation may be warranted.

Post-detoxification treatment should be guided by the type of barbiturate abuser the patient has been. For example, it would probably be appropriate to treat the concurrent barbiturate-opiate abusers as you would an opiate addict. It would, however, be clinically inappropriate to treat the individual who has kept himself in a constant hypnotic stupor the same way as the individual whose sole abuse was for the exhilaration effects of the drugs. While both types of individuals perceive themselves to be inadequate, how they used the drug to counteract this inadequacy, e.g., what the drug was doing *for* them, provides the cues for the focus of the therapeutic process. In the one case, the individual abuses the barbiturates not only to avoid interacting and competing, but also to block out anxiety or worry about this non-interaction and non-competitiveness. In the other case, the stimulation derived from the drugs and the increased activity which follows are interpreted as increasing one's efficiency and effectiveness in interactions and competition.

During 1969, the authors had an opportunity to collaborate in the collection of detailed life histories of seven barbiturate abusers who had voluntarily sought treatment for this drug-taking behavior in an experimental unit at the National Institute of Mental Health Clinical Research Center at Lexington, Kentucky. This experience has provided us with some insight into the nature of the problems which must be therapeutically resolved during treatment.

Most of these barbiturate abusers had become addicted while being legitimately treated for an undefined anxiety, stress or depression. This psycho-social symptom typically appeared after an inadequately resolved crisis in their life left them unable to cope with their problems. These abusers were able to maintain this "medicine" orientation throughout their drug careers, and were thus able to purchase their drugs legally and relatively inexpensively. In contrast to narcotic addicts, they were able to escape involvement in both the criminal and illicit drug subcultures even though they had been abusing the drugs for an average of 5.6 years.

Extensive experimentation with other drugs was prevalent among these barbiturate abusers. All had experimented with drugs other than the addicting drug. This extra-experimentation was, however, focussed upon other sedatives, tranquilizers and anti-depressants. Once addicted, this experimentation subsided.

Although all of these barbiturate abusers were being treated for the consequences of their drug-taking behavior, the abuse of drugs was only one visible indication of an inadequacy in coping with, or resolving, various psycho-social problems.

SPECIFIC PSYCHO-SOCIAL PROBLEMS REQUIRING THERAPEUTIC ATTENTION

Suicidal Gesturing

All seven of these patients reported a crisis in their lives that led them to consider seriously suicide as an alternative to coping with their difficulties. Two of the seven addict-patients reported actual suicide attempts. Commonly, there were several suicidal gesturings prior to the onset of drug abuse as well as following drug abuse. As would be expected, the gesturing following onset usually consisted of taking excessive doses of a sedative. An analysis of each life history indicated the gesturing seemed crisis – rather than process – precipitated.

Alcohol

Several of these addict-patients reported excessive drinking as having been a factor in their lives. These alcohol abusers reported their disruptive drinking behavior had terminated after they began using drugs. These addict-patients first abused alcohol in an attempt to cope with their problems and when this was unsuccessful, they began to "cope with" their problems by abusing non-narcotic drugs.

Prior Psychiatric Hospitalization

All of these non-narcotic addicts reported a history of at least one psychiatric hospitalization. The data indicate that this type of addict-patient should be viewed as a psychiatric patient – as indeed they view themselves. These non-narcotic addicts rigidly retained a self-concept of a "sick person," and even after becoming aware of their drug dependency, viewed this addiction as a medical problem to be treated with medicines.

Interpersonal Relations

All but one of these addict-patients had been married and they all reported they had experienced serious marital difficulties. The marital problems resulted in various child-rearing difficulties that left some of the children with obvious problems of their own. Further inquiry established that none of the patients had ever achieved a satisfactory interpersonal relationship with a member of the opposite sex. It can be stated that, although the patient may have been surrounded by "families" and "friends," they related only on a superficial level with minimal involvement. They appeared to be emotionally starved individuals continually pushing others from them when they became involved in an interpersonal affair. For the most part, these addict-patients presented an appearance lacking in warmth and acceptance. However, their self-imposed isolation bothered them. This was an area where a large number of psycho-social problems seemed to emanate.

It has been our experience that high-frequency, individual supportive counselling is a valuable procedure during the initial abstinence phase of treatment. The main therapeutic emphasis should be on the acquisition or sharpening of coping skills. While these abusers are more likely to have more competitive skills, e.g., education, jobs, status, intact families, etc., than the narcotic abusers, they seem to be deficient in their ability to adapt and adjust to new or stressful situations. While it is possible to impart and acquire these coping skills in group settings, individual sessions are probably more appropriate for initiating the process. Once some minimal insight and success are accomplished, the group setting where testing can occur and be analyzed is usually indicated.

Treatment During Extended Abstinence

Barbiturate abuse is best viewed as a chronic relapsing disease. As a relapsing disease, contact with the ex-abuser should be maintained for an extended period of time. While our experience is somewhat limited, the management of patients during this extended "after care" phase can be effectively accomplished in regular, but infrequent group sessions. Groups with enduring histories appear most appropriate for the rapid discovery of anxieties or depression, which too frequently signal relapse in these patients. Multiple-diagnoses groups, as well as groups comprised only of barbiturate abusers, have produced favorable results. Neither, however, has been rigorously studied for measures of outcome.

Special Considerations for the Treatment of Barbiturate Abuse

1. There is sufficient evidence to warrant the implementation of special suicide prevention procedures during the initial detoxification and abstinence phases of treatment. The incidence of suicide during these phases of treatment is apparently much greater than that found among narcotic addicts.

2. If chemotherapy appears indicated after detoxification, there is evidence that these "former drug abusers" will be less inclined to abuse the phenothiazines, reserpine, or the tricyclic anti-depressants than the minor tranquilizers.

3. Except for the persons who abuse barbiturates concurrently with other drugs, e.g., opiates or stimulants, *most* barbiturate abusers should not be treated in close proximity with the narcotic addicts. These barbiturate abusers normally will *not* have had any involvement in either the criminal or illicit drug subcultures, and the possibility of seduction and contamination should be minimized. Those who have been concurrent abusers or who have multiple addictions, have usually been involved in both the criminal and illicit drug subcultures. One can, therefore, treat these abusers with the narcotic addicts without the concerns of seduction and contamination.

4. Individuals addicted to non-narcotic drugs may be beginning to seek out public and private mental health facilities for treatment. Not only will the addicted individual need extensive treatment, other family members may also need concurrent treatment. It was noted in one study (Moffett and Chambers[5]) that the incidence of a family member's concurrently abusing drugs was high (30.0%), with most of the abusers being spouses. The mental health agency must be therapeutically prepared to accept these patients *and* their families into treatment.

5. While we, like others, have tended to treat the barbiturate-narcotic abusers as narcotic abusers, and the barbiturate-amphetamine abusers as amphetamine abusers, we have done so on the basis of expediency. Well-designed clinical research needs to be accomplished to validate these procedures.

THE NON-BARBITURATE SEDATIVE-HYPNOTIC ABUSERS

Several of the newer non-barbiturate sedative-hypnotic drugs when abused have been shown to produce intoxication, dependence, coma and/or death, resembling those due to barbiturate abuse.

Drugs		*Intoxication*	*Dependence*	*Coma/ Death*
Generic	*Brand*			
Meprobamate	Miltown, Equanil, etc.	Yes	Yes	Yes
Glutethimide	Doriden	Yes	Yes	Yes
Ethinamate	Valmid	Yes	Yes	Yes
Ethchlorvynol	Placidyl	Yes	Yes	Yes
Methyprylon	Noludar	Yes	Yes	Yes
Chlordiazepoxide	Librium	Yes	Yes	–
Diazepam	Valium	Yes	Yes	–
Oxazepam	Serax	Yes	–	–

While these drugs are indeed addicting when misused, the available evidence would suggest this addiction will occur only at dose levels considerably in excess of those therapeutically prescribed. Essig,[6-8] through his own work and through reviews of other researchers' works, has documented the abstinence effects of certain dose levels.

While our experience with treating the nonbarbiturate sedative-hypnotic abusers is too limited to permit general action, we would anticipate the treatment process to parallel the three treatment phases which have been effective with the barbiturate abusers: initial detoxification, initial abstinence and extended abstinence.

Essig,[6-8] one of the major contributors in the assessment of abuse potential and addiction liability for these drugs, has provided the clinician who is confronted with the necessity for detoxifying this type of abuser with an appropriate regimen for doing so.

Post-detoxification treatment, at least with glutethimide (Doriden) abusers, has been effective when conducted in the same manner as indicated earlier for the barbiturate abusers – high frequency individual supportive counselling sessions during the initial abstinence phase and less frequent group therapy sessions during the extended aftercare phase.

Specific research needs to be accomplished to validate which therapeutic techniques are most appropriate for which type of abuser. While we are acutely aware that therapeutic success, regardless of the technique, is intimately related to the skills of the therapist, it should be possible at some future date to predict with a greater degree of success which patients will relapse and why.

THE AMPHETAMINE ABUSERS

While there are indeed large numbers of persons who will use small doses of amphetamines without a physician's supervision for a temporary expansion of energy, e.g., students, athletes and truck drivers, this use most frequently does not occur with sufficient regularity for a dependency upon the drug to develop.

Amphetamine *abusers* appear to fall into two somewhat distinct contrasting types. While the authors are, of course, aware that a dichotomous characterization of amphetamine abusers would not be totally distinct and that there will be many gradations and exceptions, it does provide an appropriate frame within which to provide treatment services. We have chosen to label these two types of abusers as *adaptive* and *escapist*.

The *adaptive abusers* can be generally characterized as using the amphetamines to bolster their functioning within conventional interpersonal and social activities.

Drug	*Daily Dose*	*Duration*	*Significant Withdrawal Effect*
1. Meprobamate (Milltown, etc.)	4 gm	3 mos.	Convulsions
	10 gm	–	Death
	3.2-6.4 gm	40 days	Convulsions, psychotic behavior
2. Glutethimide (Doriden)	2.5 gm	3 mos.	Convulsions, delirium
3. Ethinamate (Valnid)	2-13 gm	24 mos.	Convulsions, psychotic behavior
4. Ethchlorvynol (Placidyl)	1,500 mg	months	Convulsions
	4-5 gm	1½-2 years	Convulsions, violent behavior
	2-3 gm	6-7 mos.	Convulsions
	2-2.5 gm	10 mos.	Convulsions, psychosis
5. Methyprylon (Noludar)	7.5 to 12 gm	18 mos.	Death
6. Chlordiazepoxide (Librium)	300-600 mg	5-6 mos.	Convulsions
7. Diazepam (Valium)	100-150 mg	–	Convulsions
	120 mg	–	Convulsions

This type of abuser tends to deny the abuse upon initial confrontation and when the denial is no longer possible will contend the drugs prevent or eliminate "problems" rather than cause them. This type of abuser usually has enjoyed some success in his interactions and social competitiveness, but mistakenly believes the drug permits him to recapture or increase this success. In contrast, the *escapist abusers* can be generically characterized as using the drugs so they will not have to function within conventional interpersonal and social activities. This type of abuser does not tend to deny the abuse when confronted, but has multiple ready rationalizations why it occurs. He readily admits that drugs are a problem to him. He had not normally enjoyed any success in his interactions and social competitiveness, and escapes these activities, at least at the conventional level, through his abuse of drugs.

THE THREE PHASES OF TREATMENT

The authors have found the treatment of amphetamine abusers, regardless of type, should include three distinct phases: the initial physiological detoxification phase, the initial abstinent phase and the long-term after care phase. The advocation of these three distinct phases and the therapeutic content of each is based more upon the authors' clinical deductions than extensive clinical experience. It is presented with a full awareness of patient variation and exception, but with the aim of providing an appropriate frame within which experience can be accumulated.

The initial detoxification phase of treatment is basically a medical process and should be accomplished on an inpatient basis. While there is apparently no harm in the abrupt withdrawal of amphetamines, the psychiatric reactions to amphetamine abuse, which reportedly range from acute anxiety to full-blown psychosis, may require medication, e.g., sedatives or phenothiazines. Concurrent medical problems primarily associated with the intravenous high-dose abusers may also require attention during this phase of treatment.

Excluding those cases which require extensive attention for concurrent medical problems, the initial detoxification phase should be completed within one week. This initial phase will be characterized by sleepiness. Social withdrawal, severe depression with suicidal ideas and neurasthenia have also been reported.[9-12] These characterizations appear to be appropriate for both the adaptive abusers as well as the escapist abusers and at least during this phase of treatment, the treatment procedures are basically the same for both types of abusers.

Even though there is evidence that portions of the primary withdrawal distress may continue for several weeks, it is recommended that the second phase of treatment – initial abstinence – be conducted on an ambulatory basis. The recently detoxified amphetamine abuser of both types can be expected to display chronic fatigue, flattened emotions and depression. The chronic fatigue, which continues for several weeks, has been interpreted variously as a lack of initiative, apathy and lethargy. In our experience and others,[10] an exaggerated sense of guilt occurs in most patients during the initial abstinence phase. The authors have had success with individual high-frequency supportive counselling during this phase of treatment. The main therapeutic emphasis during the frequent contacts, e.g., three one-hour sessions per week, has been on counselling only on present and future behavior. While both types of abusers profit from intensive supportive counselling in the areas of drug usage, general attitudes, domestic relations, peer relations and employment difficulties, the primary focus is somewhat different.

Supportive counselling for the adaptive abusers should be focussed upon the alleviation of neurotic-like reac-

Dichotomous Typology of Amphetamine Abusers
(Selected Characteristics)

Adaptive Abusers	*Escapist Abusers*
1. Onset was accidental medicine abuse and the medicine rationale continues	1. Onset was deliberate experimentation for a predefined euphoric effect and the euphoric rationale continues
2. Onset occurs after adulthood and after the acquisition of most major individual and social roles	2. Onset occurs prior to adulthood and before the acquisition of most major individual and social roles
3. Extensive experimentation with other drugs	3. Extensive experimentation with other drugs
4. Nonaggressive reaction to amphetamines	4. Aggressive reaction to amphetamines
5. Amphetamine of choice is not methamphetamine	5. Amphetamine of choice is methamphetamine
6. Oral use of drugs from a legal source	6. Intravenous use of drugs from an illicit source
7. Solitary abuse (hidden)	7. Group abuse (highly visible)
8. Regular – noncyclical abuse with any mood elevation a byproduct	8. Spree – cyclical abuse specifically for euphoric-stimulating effect

tions to normal interpersonal relations and social activities. It has been our experience that this type of abuser frequently is unable or unwilling to recognize his drug use as being causal to any of his problems. His rationale, of course, is that the drug eliminates his interaction difficulties, etc. Coping with the awakening feelings, which were dormant throughout the period of heavy drug use, becomes a primary therapeutic task.

In contrast, the escapist abusers have more frequently presented psychotic-like reactions to their interactions and activities. As opposed to the "uncovering" techniques utilized with the adaptive abusers, a "covering" frame of reference has proven to be effective with the escapist abusers. Other contrasts which should be considered are: (1) the escapist abuser tends to blame all of his problems on the drug with an assertion that if the therapist can assist in the maintaining of abstinence, he will have no problems and (2) being younger, as a rule, the escapist abuser has not acquired educational or occupational skills nor the values our system attaches to them.

Our experience has been that this disability usually continues beyond detoxification resulting, in part, from disabilities in functioning which pre-date drug use. Competitive skills, both at the individual and social levels, must be acquired. Habilitation, rather than rehabilitation, too frequently is the case.

In summation, during this abstinent phase of treatment, the patient should receive frequent supportive sessions as he explores his intrapersonal and interpersonal capacities without the use of drugs. The ambulatory situation with frequent therapeutic contact seems best suited for these explorations, which will probably occupy several months.

As in any type of drug abuse which produces a dependence, amphetamine dependence is most appropriately conceptualized as a chronic relapsing disorder. Once the individual patient has demonstrated some degree of continuity in conventional functioning, therapy should continue, but within a different context and within a different frame of reference.

The long-term after care phase of treatment appears to be managed most appropriately in regular but somewhat less frequent group sessions. Indices of anxiety or depression, inappropriate changes in mood or affect, inabilities to cope with stresses, etc., any of which may signal a relapse episode, seem to be more readily detected. In addition to early detection, concentrated support and guidance are more available in group therapy settings. Our experience has been that the reality therapy techniques are appropriate during this "continuous care" phase until such time as a crisis is presented or detected. At that time, the more buffering techniques of supportive therapy have produced favorable responses.

In summary, after the initial detoxification is completed, very frequent individual supportive counselling provides the therapeutic mode for reintegration. When the patient demonstrates adequate functioning, the mode can be switched to less frequent, but reenforcing group therapy sessions.

It has been our experience that the amphetamine abusers of the adaptive type *should not* be treated in proximity with the escapist type of amphetamine abusers or most narcotic addicts. It would appear appropriate to treat them in proximity with other "medicine abusers," e.g., abusers of tranquilizers, antidepressants, and some analgesic addicts who had medical or accidental onsets.

There seems to be little reason to segregate the escapist type of amphetamine abusers from narcotic addicts. Both have shared common drug experimentation patterns, illicit subcultural involvements, etc., and seduction from one group to another is unlikely. While both have their preference drugs, heroin users will also "shoot" amphetamines to enhance the effects of the opiate and amphetamine abusers will "shoot" heroin to "taper a run and prevent crashing."

Special Considerations in the Treatment of Amphetamine Abusers

1. Amphetamine abusers of the escapist type characteristically abuse their drugs in a cycle. The cycle has two basic phases – an *up*, or active phase, and a *down*, or reactive phase. The two phases are approximately equal in duration. Typically, an experienced abuser will inject the drug, usually methamphetamine, at two- to four-hour intervals for four or five days (the action phase), during which time he will remain awake continuously, and then collapse from exhaustion and remain in a semicomatose state sleeping intermittently for the next four or five days (the reaction phase).

At the onset of a "run," doses are relatively small, e.g., 50 to 100 mg, but as the run progresses, the doses increase. Kramer, et al.[11] reported the highest maximum dose known to us – a dose in excess of 1 gm taken every two hours, probably close to 15,000 mg in one day. At the peak of a "run," no quantity of drug produces the desired effects. Throughout the "run," the abuser will continue to desire to function in all of the conventional roles, but his ability do do so will deteriorate in direct proportion to the time he has been in the action phase of the cycle.

The adaptive abusers *do not* abuse their drugs in such a cycle. This type of abuser ingests drugs in a very steady, regular, and at a fairly stabilized dose level for extended periods of time. As indicated earlier, in contrast to the escapist abuser, his subjective desires to function in conventional activities and his objective ability to do so also remain fairly stable. This, of course, is not meant to suggest that this type of abuser doesn't "think" he is functioning better than he is.

2. There is considerable disagreement concerning the incidence and degree of permanent organic damage to the brain with amphetamine abuse. Representing one extreme, Lemere[9] reported that clinical, pathological and experimental studies had demonstrated permanent organic brain damage; and, for this reason, the associated psychiatric condition would be even more difficult to treat than spontaneous disorders. Kramer, et al.[11] while not testing specifically for brain damage, did discover that about a third of their respondents indicated memory and concentration impairment after their experience with high doses of amphetamines. Most recently, Connell[12] summarized the question in the following manner: . . . "The present position would seem to be that there is no conclusive evidence of permanent brain damage, but there may well be a basis for such an eventuality in terms of the clinical, animal, physiological, neurochemical, and neurophysiological findings."

If indeed permanent brain damage does occur, the clinician should consider this when establishing treatment expectations and goals with the patients. In the few cases where standardized psychological tests were available, the authors have not encountered any organic brain damage which could be attributed to drug use. *Large-scale dose- and time-related research studies are needed to determine the incidence and degree of permanent organic brain damage among amphetamine abusers.*

3. Numerous writers have addressed themselves to the aggressiveness of what we have labelled the escapist type of amphetamine abusers.[9,11-16] This behavior, variously labelled as aggressive, assaultive, violent, compulsive, suspicious, paranoid and impulsive, may in some patients present a major management problem. While the physical danger to other patients or treatment personnel is probably no greater than that encountered in the treatment of psychotic patients whose problems were not drug induced, it does warrant the clinician's awareness. Smith[15] has suggested that these high-dose mainliners of amphetamines are the most – and probably the only – dangerous drug abusers to treat. Our own experience would support this contention. Unfortunately, it has not been possible to predict when a violent eruption will occur with this type of abuser. While paranoid reactions and impulsive violence most frequently occur during the initial detoxification phase of treatment, episodes have been encountered throughout the treatment process. Violence during the initial detoxification phase seems best countered with a general nonthreatening calmness. Our limited treating experience would indicate that the episodic eruptions which occur after detoxification are best countered with more direct methods, e.g., by the direct use of authority and the labelling of the behavior as inappropriate and not to be tolerated. This authoritative setting of limits does not appear to "feed" the paranoid delusions or suspiciousness, and this is undoubtedly related to the insights gained during treatment. Other writers[11,16] have also noticed the "pseudodelusional" character of these abusers' paranoid ideas. The degree of conviction with which the abuser holds these "pseudodelusions" and the impulsivity with which he reacts to them is probably related to the amount of elapsed time abstinent. The greater the amount of time abstinent, the less the conviction with which the delusion is held, and the less likely an impulsive aggressive reaction to the delusion.

4. The question as to the incidence and whether amphetamine psychosis is dose-related deserves close clinical and research attention. At the present time, the literature reflects both polar positions. Ellinwood's[17] work would indicate that this psychosis is dose-related, e.g., the greater the dose the greater the probability of producing the psychosis. Lemere's[9] work, on the other hand, suggests this relationship is not so predictable. He presents the case history of a 47-year-old who had ingested a daily dose of only 30 mg of dextroamphetamine, ostensibly for weight reduction, over a period of four years. A paranoid psychosis reportedly ensued with some organic deterioration that had persisted even after discontinuation of the drug.

If indeed a paranoid psychosis does occur with any regularity at such low doses, a special problem is presented to the social system. For example, at these low doses the person taking the drugs will still be capable of conventional functioning throughout his drug-taking career until the paranoid psychosis erupts. If this eruption should include the all-too-common components of aggressiveness and violence, a significantly dangerous situation could ensue involving those around the abuser, e.g., his fellow workers, his family, fellow commuters, etc.

Large-scale, carefully controlled dose- and time-related research is of the highest priority, to determine the incidence and degree of amphetamine psychosis. Well-designed, time-related follow-up studies are also indicated, which would determine the recovery potential during abstinence. These research efforts also need to include studies to isolate those psychoses which were essentially toxic reactions to the abuse, and the others which were precipitated or triggered in the borderline individual.

5. Clinicians must be constantly alert to the possibility of a multi-dependent patient. These abusers will use a wide variety of drugs, together or sequentially, according to the vaporous notions of the person and the availability of the drugs. Heroin addicts have long combined their drugs to produce prolonged or intensified reactions, e.g., cocaine, amphetamines and barbiturates, but the multidependent abuser appears to be much more prevalent than in the past. Opiate addicts who "boost" their injections with sedatives and high-dose intravenous

amphetamine abusers who "taper runs" with various analgesics, frequently are unaware of their multiple dependencies. Carefully detailed drug histories, including all drugs and the extent of their use, are necessary components of the intake examination. While an opiate withdrawal can normally be conducted safely on an ambulatory basis, the superimposition of a sedative, tranquilizer or stimulant dependency would indicate an inpatient detoxification.

Probably as many as 5% of all heroin addicts are also high-dose amphetamine abusers, and as many as 35% of all heroin addicts are concurrently addicted to a sedative.

THE HALLUCINOGENIC ABUSERS

The Drugs

Hallucinogenic drugs include LSD, a semi-synthetic derivative of ergonovine, whose effects were first accidentally discovered by Albert Hofmann in 1943; mescaline, a phenethylamine present in the buttons of a small cactus (mescal, peyote); psilocybin, an indole found in a mushroom (teonanacatl); DMT (dimethyltriptamine), a synthetic indole found in the seeds of a South American plant; DOM or dimethoxyamphetamine, otherwise known in Haight-Ashbury as STP, an abbreviation for "serenity, tranquility, and peace"; and the seeds of some morning glory varieties (Oloiuqui), the active principle of which is closely related to LSD. Marijuana, which has hitherto been mistakenly classified as a narcotic and with hard drugs, is increasingly being viewed as a mild hallucinogen. Most of our knowledge concerning these drugs has been accumulated with LSD. This section is, therefore, directed primarily to the LSD abusers.

LSD, in crude form, is relatively simple to synthesize given a supply of lysergic acid or one of the ergot alkaloids. Lysergic acid can, in turn, be produced by deep fermentation processes fairly readily, if there is suitable equipment and knowledge. The synthesis of lysergic acid is very difficult, however. DMT is a newer synthetic, with a shorter and harsher action than LSD, a "trip" usually lasting about two hours.

LSD was first described as a "psychotomimetic" drug, producing a "model psychosis" because it was assumed to have many similarities to psychosis; i.e., it "mimicked" psychosis. A similarly inaccurate description used has been "hallucinogenic" though it is agreed LSD does not produce true hallucinations since the subject may be aware of what is happening, i.e., there is a "spectator ego" witnessing all the excitement – a sort of split of self, with one part observing, the other participating. The most recent term of "psychedelic," meaning "mind-manifesting," is deemed more acceptable today though it too raises a question as to whether LSD is indeed generally consciousness-expanding in the sense implied by some advocates.

The Effects of Abuse

LSD is not physically addicting in the sense of barbiturates and opiates. The dependence is psychological, not physical. Tolerance develops rapidly after a few days of repeated use, but is usually lost in two or three days. Some users have built up their LSD doses to 1000 and 2000 mcg over a period of days. The first or threshold dose is about 25 mcg and an average dose is 200 to 400 mcg. Cross-tolerance exists among LSD, psilocibin and mescaline, though tolerance to mescaline develops more slowly than to the other two. Paradoxically, some users report a state of increased sensitivity to LSD once they have lost their tolerance. Unexpected return of the drugged state without ingestion of LSD for months or even a year later has been reported. Some people in the drugged state may pay attention to auditory frequencies they normally ignore and thereafter continue to be sensitive to these frequencies.

To date, neither the mode nor site of action of LSD is known, but it has central, peripheral and neurohumoral effects. Physiologically, the effects of psychedelic drugs resemble those produced by sympathomimetic drugs such as: increased pulse rate and blood pressure, dilated pupils, tremor and cold, sweaty palms, and at times, flushing, shivering, chills, pallor, salivation, dysrhythmic breathing, nausea, anorexia and urgency.

Drug-induced activity lasts 8-12 hours, with the most intense changes in sensation, mood and perception occurring during the first half of the experience, the latter part being marked by introspection and hypersuggestibility. A change in mood is the first obvious behavioral change observed. Along with this, is a tremendous increase in sensory input, a kind of flooding, with perceptual distortions and hallucinations. "Synesthesia" often occurs, i.e., a crossover of the different senses: subjects can "hear" colors, visualize music as colors, or "taste" sounds. There is also "tunnel vision," the focussing in on minute details not observed before.

The literature reports three different kinds of experiences under LSD: (1) *the good trip* – a predominantly pleasing experience; (2) *the bad trip* – a dysphoric experience characterized by anxiety, panic, feelings of persecution, fears of loss of ego boundaries, loss of control and time perception, and impaired performance; and (3) an *ambivalent state* where the subject may simultaneously experience contrasting feelings as of happiness and lightness, relaxedness and tenseness (Mayer[18]).

The *bad trip* has been well documented in the literature. It has been described as psychological and attributable to the panic emergency upon experiencing a host of overwhelming sensations. Learning was entailed and described in relation to marijuana use. Frosch[19] reported that, in a 2½ year period, some 250 persons were admitted to Bellevue with mental disorders either directly attributable to LSD or where the drug played a major role in bringing about the disorder. Patients admitted remained from a few days to several months, and a few were transferred to State hospitals.

Another study[20] was made of 70 post-LSD psychiatric admissions during a 6-month period in a Los Angeles medical center, these patients representing 12% of all admissions. One-third of the LSD patients were psychotic on admission and two-thirds required more than one month of hospitalization.

The negative experiences which a clinician may encounter during the management of these patients have been summarized[18] as follows:

Acute Reactions

The acute reactions – the bad trips – are of two types:

1. Psychotoxic reactions which are characterized by confusion and/or acute paranoia, feelings of omnipotence and invulnerability, which may cause the user to expose himself to dangers resulting, at times, in injury or death.
2. Panic reactions which occur as a secondary response to the drug-induced symptoms.

One may anticipate fairly rapid recovery from these two acute states. Remission usually occurs within two or three days with the recommended treatment of sedation and verbal support.

Recurrent Reactions

These reactions are the spontaneous return of perceptual disorders or feelings of depersonalization, occurring up to a year after the last use of the drug. Frosch[19] believes these recurrent symptoms are associated with stress or anxiety in the patient. Others[21] feel they may be symptomatic of brain lesions. Blacker[22] found no EEG evidence of classically defined organic brain damage in chronic LSD users.

Prolonged Reactions

These reactions are the chronic anxiety states and chronic psychoses resulting from LSD administration, persisting beyond the period of acute intoxication.

Significant variables determining the cause of any LSD trip are: the personality and expectations of the subject, the presence of a dependable guide, the nature of the setting in which the drug is taken, and the age of the subject. Younger subjects were noted to have experienced acute reactions more frequently.

Smith[23] has described a cultogenic "psychedelic syndrome" among hippies in the Haight-Ashbury area. Members do not feel themselves to be mentally ill, and are not considered ill by fellow members of their community. As long as the individual remains in the hippie subculture, he can survive and handle his internal conflicts, and treatment of any kind becomes impossible. Some observers believe that chronic use brings about sharp personality changes, a greater receptivity to excitement and stimuli, magical thinking and poor organization which cannot be explained psychologically alone.

Treatment

For the acutely intoxicated state, the American Medical Association[24] recommends the LSD abuser have an immediate trial with phenothiazine medication, preferably administered intramuscularly since the phenothiazines block the action of LSD. He further suggests barbiturates can be used in lieu of, or in addition to the phenothiazines. Because the hallucinogens do not cause physical dependence, there are no physical complications of withdrawal. Care should be exercised, however, to learn whether other addicting drugs were taken concurrently with the LSD, which may require a separate detoxification regimen. Once the acute reaction or panic has subsided, sedatives or tranquilizers have been recommended.

Some clinicians place more emphasis upon pleasant surroundings and psychological supports during the initial treatment phase than upon medication.

The duration of the initial treatment of the acutely intoxicated abuser is relatively short – 12 to 72 hours. Once this period of intoxication is over, and if symptoms of mental illness are apparent, any medication prescribed should be on the same basis as for a similar type of mentally ill person who has not been involved with hallucinogens.

Post-detoxification treatment during initial abstinence is probably best managed if it is focussed upon coming to grips with any psychological dependency produced by the abuse. As with any drug which produces a psychological dependency, the dependency produced by LSD abuse continues long after the physiological effects have dissipated. Sympathetic supportive counselling seems to be most effective during post-detoxification treatment.

Extended therapeutic contact with the ex-abuser of LSD is imperative for two reasons. First, after psychedelic intoxication there is always the possibility of spontaneous recurrence, and second, this contact is the only way in which the clinician can ascertain if the acute reactions are indicative of a chronic abuse pattern.

Special Considerations for the Treatment of LSD Abusers

1. While our information about the biologic hazards of LSD and other hallucinogenic drugs must be considered incomplete and requiring additional research, the evidence is such that women in the childbearing age should be cautioned concerning this possibility.

2. Clinicians must be continuously alert for symptoms other than those anticipated from the drug history taken from the patient. It is becoming apparent that large numbers of patients cannot be certain which drugs they have been taking. Recent studies[25] have shown many of the hallucinogens sold on the illicit market are "mislabelled" and vary widely in potency. What was thought to be mescaline or psilocybin may indeed be LSD which

will greatly panic the users. If DOM (STP) has been ingested rather than LSD, phenothiazines, especially in high doses would be contraindicated since they seem to prolong the acute reactions. In addition, spontaneous recurrence of the acute reactions is more frequent with DOM (STP) than with LSD.

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